

- Name of other insurance carrier/administrator _____
- Policy Holder's Name _____
- Have these claims been processed by your other insurance?

Yes
No

SECTION E – TO BE COMPLETED BY FUND OFFICE ONLY

- Claim should be paid at 80% after the applicable co-pay.
- Claim should be paid at 100% after the applicable co-pay.

Reason for this manual reimbursement request _____

Authorized Human Resources Signature

Date

**PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND
 FILL OUT REVERSE SIDE OF THIS FORM.**

SECTION A. Subscriber Information (The Subscriber is the insured member whose employer provides this benefit.)

1. Print Subscriber's name (last, first, middle initial)
2. Print Subscriber's ID number (found on prescription drug or Health Insurance card)
3. Print Subscriber's mailing address and phone numbers
4. Indicate Subscriber's employer, insurance carrier and group number (refer to drug card)
5. **IMPORTANT: CLAIM FORM MUST BE SIGNED. (UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED)**

SECTION B. Patient Information (Complete this section for each family member who has received medication.)

1. Print Patient's name
2. Identify relationship to subscriber, gender, date of birth, number of prescriptions, and total dollar amount for each patient
3. Total the number of prescriptions and total dollar amount for all patients for which claims are being submitted for processing at this time

SECTION C. Prescription Information Submit either prescription receipts/labels with this claim form or a patient history print-out from your pharmacy. It is preferable to have them unattached. Please don't staple, tape or glue. Claims received missing any of the following information may be returned or payment may be denied.

- | | |
|-----------------------------|---------------------------|
| • Pharmacy name and address | • Rx Number |
| • Drug name and strength | • Quantity and Day Supply |
| • Date filled | • Price |

Note: Altered receipts require pharmacist signature.

SECTION D. Other Coverage Information

1. Indicate if other family members are covered under another drug plan
2. Print name of other insurance carrier/administrator for that plan
3. Print name of family member who holds other policy
4. Indicate if the claims enclosed have been processed by other insurance

SECTION E. This sections is used by the Fund Office for approval of payment of your claim.

**Please return this claim to: St. Louis Graphic Art Joint Health & Welfare Fund
 14323 South Outer Forty Road, Suite N204
 Chesterfield, MO 63017**

Questions? You may contact one of the following

Express Scripts Customer Service Department at 1-877-494-7476

St. Louis Graphic Arts Joint Health and Welfare Fund at (314) 275-8080