



**UNITED FOOD AND COMMERCIAL WORKERS UNION, LOCAL 464A
WELFARE FUND PRESCRIPTION CLAIM FORM**

245 PATERSON AVE.
LITTLE FALLS, NJ 07424
(973) 256-6790

*** ORIGINAL PAID RECEIPTS MUST BE ATTACHED TO THIS CLAIM FORM ***



THIS PART MUST BE COMPLETED BY MEMBER

| | | | | | |
|-------------------------|-------|---|-------------------|--|------------------|
| Name | | | Social Security # | | Birth Date |
| Street | | | Employer/location | | |
| City | State | Zip Code | Home Phone # | | Business Phone # |
| Patient's Name | | Is patient covered by any other prescription plans? | | | |
| Patient's Date of Birth | | Were any of these drugs prescribed due to an accident? | | | |
| Relationship to Member | | Were any of these drugs prescribed due to an on the job injury? | | | |
| Members Signature | | | Date | | |

YOU MUST USE A SEPARATE FORM FOR EACH FAMILY MEMBER

THIS PART MUST BE COMPLETED BY PHARMACIST

| | | | | | |
|----------------------|-------|----------|---|--|--|
| Name of Pharmacy | | | Pharmacy Phone # | | |
| Street Address | | | Name of Patient | | |
| City | State | Zip Code | Did this patient receive a senior citizen discount? | | |
| Pharmacist Signature | | Date | Does this patient have any other prescription coverage? | | |

**NO PAYMENT WILL BE MADE FOR ANY LEGEND DRUGS BEYOND A 34 DAY SUPPLY.
CLAIMS ARE VOID IF SUBMITTED BEYOND 90 DAYS OF DATE DISPENSED.**

| | | | | | | | |
|------------------|---------------|--------------|--------------|-------------|-------------------|-------------|----------------|
| Date dispensed | NAT DRUG-CODE | Strength | Quantity | Days Supply | RX Number | New/Refill? | Amount Charged |
| Physician's Name | | Name of Drug | Manufacturer | Dosage Form | Direction for Use | | |

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|------------------|---------------|--------------|--------------|-------------|-------------------|-------------|----------------|
| Date dispensed | NAT DRUG-CODE | Strength | Quantity | Days Supply | RX Number | New/Refill? | Amount Charged |
| Physician's Name | | Name of Drug | Manufacturer | Dosage Form | Direction for Use | | |

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