# OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUNDS

**P O BOX 7067, PASADENA, CA 91109**

## FEE-FOR-SERVICE

## PRESCRIPTION DRUG CLAIM FORM

**ENGINEER'S SOC. SEC. NO: _____-_____-_____ ENGINEER'S NAME: _____**

**PATIENT NAME: _____ PATIENT DATE 0F BIRTH: ___/___/___ RELATIONSHIP TO ENGINEER: _____**

**ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____**

**MEMBER'S HOME PH0NE NO: _____ IS CLAIM/RX WORK RELATED? YES☐NO☐**

****COMPLETION OF THIS ENTIRE FORM (BY A LICENSED PHARMACIST) IS REOUIRED FOR REIMBURSEMENT****

| RX # | NAME & STRENGTH OF MEDICATION | NEW RX | REFILL | METRIC QUANTITY | DAYS SUPPLY | NDC# OF MEDICATION | RX PRICE | DATE WRITTEN | DATE FILLED | PRESCRIBER DEA # |
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**PHARMACY NAME: _____ NABP NUMBER: _____**

**PHARMACY PHONE#: (_____)_____ PHARMACIST'S SIGNATURE: _____**

**REIMBURSEMENT FOR ALL PRESCRIPTIONS PURCHASED AT NON-CONTRACT PHARMACIES ARE LIMITED TO A SIXTY (60) DAY SUPPLY (ON EACH INDIVIDUAL MEDICATION) LIFETIME, WITH NO EXCEPTIONS, FURTHER MEDICATION SUPPLY MUST BE OBTAINED THROUGH THE FUNDS CONTRACT PHARMACY FOR REIMBURSEMENT.**

**INFORMATION REGARDING THE TRUST FUND'S PRESCRIPTION DRUG PLANS CAN BE FOUND IN YOUR BENEFIT BOOK, BENEFIT UPDATES, BY CONTACTING THE TRUST FUND'S INFORMATION CENTER AT (626) 356-1004 OR BY ACCESSING THE TRUST FUND'S WEBSITE AT WWW.OEFUNDS.ORG.**

REVISED 01/2001