



Hawaii Electricians Health & Welfare Fund

1935 Hau Street, Room 300, Honolulu, Hawaii 96819
 Phone (808) 841-6169 / Fax (808) 847-4596
 Neighbor Islands (Toll Free) 1-800-622-3830

Pharmacy Direct Member Reimbursement Claim Form

Claims must be filed within 90 days of date purchased. This form is for member reimbursement requests only. Use a separate claim form for each patient.

To avoid claim returns and errors: 1) Please attach prescription receipts, and 2) Have Provider sign form.

PART A			<i>Subscriber: Please complete all Part A areas</i>		
Print Subscriber's Name:		Subscriber's Social Security Number:		Plan or Group Number: 1186	
Patient's Full Name:		Male <input type="checkbox"/> or Female <input type="checkbox"/>		Birthdate: ___/___/___	
Prescribed by (Name of Prescriber):		Circle Patient's Relationship to Subscriber: Member; -01 Spouse; -02 Dependents; -03 -04 -05 -06			
Is treatment result of a job related injury?....Yes <input type="checkbox"/> No <input type="checkbox"/>		Is treatment result of auto accident?.....Yes <input type="checkbox"/> No <input type="checkbox"/>			
Is patient covered by another drug plan?....Yes <input type="checkbox"/> No <input type="checkbox"/>		Other type of accident?.....Yes <input type="checkbox"/> No <input type="checkbox"/>			
Please indicate: Primary Plan Name: _____ Secondary Plan Name: _____ Other pharmacy insurance co-pay structure: Brand: _____ Generic: _____ Non-Preferred: _____ I hereby authorize any pharmacy or provider to disclose the drug information of the prescription named hereon to <i>R/x</i> ^x and/or the Hawaii Electricians Health & Welfare Office. I also certify that I have received the prescription(s) that are shown below.					
_____ Signature of Subscriber				_____ Date	

PART B								<i>Provider: Please complete all Part B areas</i>							
Rx number	National Drug Code (NDC)	Qty	Day Supply	Date Dispensed Month / Day / Year	Cost of drug	Co-pay amount	Processed Online?								
							Y or N								
							Y or N								
							Y or N								
							Y or N								
							Y or N								
I certify that the above Part B information is true and correct.															
Totals:															
_____ Signature of Provider								_____ Date							
_____ Provider / Pharmacy Name, Address and Phone Number								_____ Provider NABP Number							

Claim should be mailed in an envelope to Hawaii Electricians Health & Welfare Fund, Attn: Pharmacy Claims at above address.
Please keep a copy of this claim for your records.