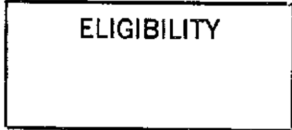
CONTRACTORS, LABORERS, TEAMSTERS & ENGINEERS
HEALTH AND WELFARE PENSION PLAN
10334 Ellison Circle
Omaha, NE 68134
402-491-3751 • FAX 402-491-0902

OUT-PATIENT DRUG CLAIM FORM
(Separate Form to be Used for Each Member of Family)



PLEASE NOTE:

This Form Must Be Completed by the Pharmacist

PLEASE NOTE—Unless the doctor prescribing medicines has been billing the Plan for his services, a doctor's form must be submitted to indicate the illness for which the drugs have been prescribed. Avoid delay and/or return of drug charges by meeting this requirement.

Name of Member.. Social Security Number..................

Address... Union Local #................

Name of Patient.................................. Age........ Sex........ Relationship.................

SALES TAX AND NON Rx ITEMS NOT COVERED

Do not include drugs that can be purchased without a doctor's prescription.

Date of Purchase	Rx Number	Name of Drug	Charge for Drug	Doctor Prescribing Drug

IMPORTANT:

Must Be Signed by Pharmacist →

I certify the above Rx drugs were purchased for the patient named and do not include drugs that can be purchased without a doctor's prescription.

....
Date Pharmacist Signature

....
Name and Address of Pharmacy

I certify the above statement to be correct.

Must Be Signed by Insured Member →

....
Date Member Signature