

United Food & Commercial Workers Unions & Employers Midwest Health Benefits Fund
United Food & Commercial Workers Union & Employers Calumet Region Insurance Fund

2625 BUTTERFIELD RD, SUITE 208E, OAK BROOK, IL 60523
 800-621-5133 * FAX 847-384-0197 * www.ufcwmidwest.org

Coordination of Benefits (COB) — Prescription Drug Claim Statement
 (This COB claim is for the difference in payment due)

Submit pharmacy receipts—not cash register receipts—with this claim form

Cardmember (Employee-Member) Information					
YOUR FULL NAME (EMPLOYEE-MEMBER)				UFCW ID# or SOCIAL SECURITY NUMBER	
STREET ADDRESS		CITY		STATE	ZIP
					CHECK <input checked="" type="checkbox"/> IF NEW ADDRESS <input type="checkbox"/>
Patient Information					
PATIENT'S FULL NAME—FIRST AND LAST NAME			RELATIONSHIP TO EMPLOYEE-MEMBER		DATE OF BIRTH
			<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILD
			<input type="checkbox"/> MALE		
			<input type="checkbox"/> FEMALE		
IF PATIENT IS SPOUSE OR CHILD, EMPLOYER NAME AND ADDRESS					CHECK <input checked="" type="checkbox"/> IF NOT EMPLOYED <input type="checkbox"/>
Other Insurance Information					
POLICYHOLDER'S FULL NAME—FIRST AND LAST NAME				DAYTIME AREA CODE/PHONE NUMBER	
NAME OF OTHER INSURANCE PLAN OR COMPANY				POLICY NUMBER	
ADDRESS		CITY		STATE	ZIP
					AREA CODE/PHONE NUMBER
Signatures—Employee-Member and Patient (or Parent, if patient is a minor) must sign or benefits cannot be paid					
I certify that the patient information above is correct, that the patient named is eligible for the benefits, and that I have received the medication described below. I further certify that the medication received is not for treatment of an on-the-job injury. I agree that the "Total Cost to Claimant" below is the balance due after the other insurance payment was made. I authorize the release of all information on this form to the UFCW Midwest Health Benefits or the UFCW Calumet Region Insurance Funds, underwriter, sponsor, policyholder and employer.					
Date _____		Signature _____			Employee-Member sign here
Date _____		Signature _____			Patient (or Parent) sign here
Pharmacist—Please Complete this Section (please print)					
DATE Rx FILLED	Rx NUMBER		<input type="checkbox"/> NEW <input type="checkbox"/> REFILL	DAYS SUPPLY	METRIC QUANTITY
NATIONAL DRUG CODE			DRUG DESCRIPTION AND STRENGTH		TOTAL EXPENSE
PRESCRIBER'S NAME AND DEA NUMBER				PLAN PAYMENT	
				TOTAL COST TO CLAIMANT	
PHARMACY NAME			NPA/NABP ACCOUNT NUMBER		
Date _____					Pharmacist sign here