United Food & Commercial Workers Unions & Employers Midwest Health Benefits Fund
United Food & Commercial Workers Union & Employers Calumet Region Insurance Fund
18861 90TH AVE, SUITE A, MOKENA, IL 60448
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 ☑ IF NEW ADDRESS ☐

Patient Information

PATIENT'S FULL NAME—FIRST AND LAST NAME	RELATIONSHIP TO EMPLOYEE-MEMBER	☐ MALE ☐ FEMALE	DATE OF BIRTH
	☐ SELF ☐ SPOUSE ☐ CHILD		

IF PATIENT IS SPOUSE OR CHILD, EMPLOYER NAME AND ADDRESS	CHECK ☑ IF NOT EMPLOYED ☐

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	☐ NEW ☐ REFILL	DAYS SUPPLY	METRIC QUANTITY	TOTAL EXPENSE

NATIONAL DRUG CODE	DRUG DESCRIPTION AND STRENGTH	PLAN PAYMENT

PRESCRIBER'S NAME AND DEA NUMBER	TOTAL COST TO CLAIMANT

PHARMACY NAME	NPA/NABP ACCOUNT NUMBER

Date _____ Signature _____ **Pharmacist** sign here

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