SOUTHERN CALIFORNIA PIPE TRADES
HEALTH & WELFARE FUND
PENSIONERS & SURVIVING SPOUSES HEALTH FUND
501 Shatto Place, 5th Floor, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 487-3640 | www.scptac.org

PRESCRIPTION DRUG CLAIM FORM

If you or your eligible dependent incurs expenses for drugs or medicines lawfully obtainable only upon prescription of a Physician, Podiatrist, or Dentist, and when related to a diagnosis, and dispensed by a licensed U.S. pharmacy, you will be reimbursed for a portion of the charges incurred, depending on total charges in the Calendar Year, after applying a separate $50 deductible. Please see plan rules for additional information.

PART 1: PLAN PARTICIPANT INFORMATION

NAME		**ADDRESS** *(Street, City, State, ZIP)*
SSN	*(only the last four digits are required)* - -	

PART 2: PATIENT INFORMATION

NAME		**ADDRESS** *(Street, City, State, ZIP)*
SSN	*(only the last four digits are required)* - -	

PART 3: MEDICATION INFORMATION

Attach itemized prescription receipts or computer printouts to this form and forward to the Fund Office at the above address. Receipts and printouts must include the patient's name, the date prescription was filled, the name of the medication, the prescription number, the cost of the prescription, and the name of the prescribing physician.

COMPUTER PRINTOUTS OF PRESCRIPTIONS MUST BE SIGNED AND DATED BY THE PHARMACIST

Date of Purchase	Name of Medication	RX Number	Amount

PART 4: SIGNATURES

PARTICIPANT		**DATE**	
PATIENT		**DATE**	