

WESTCHESTER C.O.B.A. WELFARE TRUST FUND
Co-Pay/Prescription Reimbursement Claim Form

MEMBER NAME: (print last name first)		ACTIVE <input type="checkbox"/>	RETIREE <input type="checkbox"/>
HOME ADDRESS: Number & Street	Apt #	Contact Phone #	
CITY	STATE	ZIP	

I certify that the information given is correct and authorize release of any information necessary to process this claim.

MEMBER

SIGN HERE _____ **DATE** _____

Valid **proof of** payment must be provided in order to be reimbursed. Please include copies of co-pay/prescription receipts, prescription printout from your pharmacy, DR/ER visit printout that shows payment(s) made, copy of bank/credit card statements or copy of cancelled check as proof of payment. **Explanation of Benefits (EOB) from your insurance carrier is NOT acceptable as proof of payment.**

CLAIMS WILL ONLY BE PROCESSED FROM FEBRUARY 1, 2023 THROUGH FEBRUARY 28, 2023

CLAIMS POSTMARKED AFTER FEBRUARY 28, 2023 WILL NOT BE CONSIDERED.

REIMBURSEMENT MAXIMUM \$300 PER MEMBER

	DATE	EXPENSE	AMOUNT
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
TOTAL AMOUNT			

Use reverse side for added submissions

PLEASE RETURN FORM TO:

WESTCHESTER C.O.B.A. WELFARE TRUST FUND
P.O. BOX 231
THORNWOOD, NEW YORK 10594
(914) 773-0436 PHONE (914) 773-0439 FAX
WCOBAWELFAREFUND@WESTCHESTERCOPA.ORG

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	DATE	EXPENSE	AMOUNT
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
TOTAL AMOUNT			

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