PSC CUNY Welfare Fund

61 Broadway, 15th Floor
New York, NY 10006
Phone: 212-354-5230 Fax: 212-354-5363

Prescription Reimbursement Form

File within 90 Days of Services

Member

Last Name _____ **First Name** _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Social Security Number _____

Retiree of (College) _____

Claim Filed for : ☐ Self ☐ Spouse ☐ Joint Submission [Both]

Please Check One: ☐ Application to Reimburse for **Rx Rider**

Attach Proof *e.g., Pension Pay Stub*

☐ Application to Reimburse for **Rx Expenses**

Attach Proof *e.g. Receipts or Pharmacy Print-out*

Amount Claimed: $ _____ An amount must be entered.

Please Note Reimbursement is limited to $400 per family per year.

Receipts or other attachments cannot be returned. Copy before sending if necessary.

Member Signature _____ **Date** _____

For Office Use Only

Approved _____ **Date** _____