DISTRICT NO. 9, I. A. OF M. & A. W. WELFARE TRUST

12365 St. Charles Rock Road ■ Bridgeton, MO 63044
(314) 739-6442 ■ (888) 739-6442 ■ fax (314) 739-2374
www.d9trusts.org

PRESCRIPTION DRUG REIMBURSEMENT CLAIM FORM

For payment: we must have the original bills which contain the patient's name, name of medication, full cost, date of purchase, prescribing doctor and the NDC number.
For payment as secondary, we need the above information along with the full cost of the drug and the co-pay or amount paid.

Member Name: ______ Last / First / MI	Member ID #: ______		
Home Address: ______ Street ______ City / State / Zip	Is Member: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated	Is Patient: ☐ Self ☐ Spouse ☐ Dependent	Does patient live with member: ☐ Yes ☐ No
Home Phone:	Employer:		

Patient Name: ______	Date of Birth: _____/_____/_____	☐ Male ☐ Female
Is patient covered by any other insurance? ☐ No ☐ Yes	If "yes", name of insurance carrier. ______ Through what employer or organization is plan provided? ______	
Is illness or injury for which this drug has been prescribed caused by work? ☐ No ☐ Yes If "Yes", explain:		
Signature of Member:	Date	

FROM ______ TO ______ CLASS ______

FROM ______ TO ______ CLASS ______

FROM ______ TO ______ CLASS ______

FROM ______ TO ______ CLASS ______

COMPANY PAID THROUGH: ______

BILLS FOR CALENDER YEAR: ______