Frankfort-Schuyler CENTRAL SCHOOL

COPAY REIMBURSEMENT FORM
FSTA UNION MEMBERS & RETIREES
UPDATED 1.24.2020

PLEASE PRINT CLEARLY:

NAME: _____

ADDRESS: _____

_____

PHONE: _____

TOTAL SUBMITTED FOR REIMBURSEMENT (FROM PAGE 2): $_____

The fiscal year end for the reimbursement pool is June 30th. Claims must be submitted within 15 days (postmarked by July 15th) of year end to be eligible for reimbursement. Claims from the prior fiscal year submitted after July 15th will not be eligible for reimbursement.

Frankfort-Schuyler Central School District has established a $**40,000 for 2019/20 and $32,000 each year for 2020/21, 2021/22 and 2022/23** fund to offset out of pocket copay increases until this fund is depleted annually (on a fiscal year basis). To be eligible for reimbursement, the following criteria must be met:

- The reimbursable expense must relate to eligible prescription drug copay expenses incurred by insured and/or insured's eligible dependents.
- Claimant must provide the tier under which the prescription falls.
- Claimant has attached evidence of payment to this form.
- In the event that less than $5 is paid for tier 1, $20 for tier 2 and $40 for tier 3 prescriptions, no copayment reimbursement is allowed.

I have read the criteria outlined above and the instructions provided on the reverse of this form.

_____ _____
Claimant's Signature Date

Submit this signed form and corresponding evidence of payment to:

Kacey Sheppard-Thibault
Attn: CBO Copay Reimbursement
605 Palmer Street
Frankfort, NY 13340

FRANKFORT-SCHUYLER CSD
COPAY REIMBURSEMENT FORM

Reimbursement Schedules

Rx Purchased In Pharmacy	Previous Copay Allowance	New Copay Paid By Insured	Eligible Reimbursement
Tier 1 Drug	$5.00	$15.00	$10.00
Tier 2 Drug	$20.00	$30.00	$10.00
Tier 3 Drug	$40.00	$45.00	$5.00

90 DAY Rx Purchased	Previous Copay	New Copay Paid By Insured	Eligible Reimbursement
Tier 1 Drug	$10.00	$30.00	$20.00
Tier 2 Drug	$40.00	$60.00	$20.00
Tier 3 Drug	$80.00	$90.00	$10.00

Please attach pharmacy and/or mail order, receipts. Reimbursement will not be made unless corresponding receipts are attached.

Complete one entry for each receipt attached. Additional forms may be attached as needed.

Date of Service	Pharmacy, Mail Order Company, or Health Care Provider Where Service Was Provided	30 or 90 day Supply	Tier (1, 2 or 3)	Amount Paid	Reimbursement Claimed
	TOTAL				**$**

Please enter total reimbursement claimed on front of form