SOUTHERN CALIFORNIA PIPE TRADES ADMINISTRATIVE CORPORATION
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 386-0418 | Email info@scptac.org | www.scptac.org

PRESCRIPTION DRUG CLAIM FORM

If you or your eligible dependent incur expenses for drugs or medicines lawfully obtained 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 a Calendar Year, after applying a separate $50 deductible. Please see plan rules in your Summary Plan Description for additional information.

Part 1 Patient Information

NAME	First, Middle, Last	**RELATIONSHIP TO PARTICIPANT**	
DATE OF BIRTH	mm/dd/yyyy / /	**SOCIAL SECURITY NUMBER**	(Only last four digits required) - -

Part 2 Participant Information

NAME	First Name Middle Initial Last Name		
PARTICIPANT ID	Blue Shield of California **IPE T50**	**OR**	Social Security Number (Only last four digits required) - -
ADDRESS	Street City State ZIP		
PHONE NUMBER	( ) -	**EMAIL**	

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 National Drug Code (NDC) number, the cost of the prescription, the name of the prescribing physician.**

Date Filled	Name of Medication	RX Number	NDC Number	Amount

Part 4 Authorization

I authorize the Fund Office to execute my directions as set forth above.

PARTICIPANT SIGNATURE X	**PRINT NAME**	**DATE**
PATIENT SIGNATURE (Parent or Legal Guardian, if Minor Child, or Personal Representative) X	**PRINT NAME**	**DATE**