City College of San Francisco
S / h Prescription Drug Co-Payment Reimburse Form

Please read the Rules & Guidelines printed on the back before completing this form
(Attach original receipts/documents to the back)

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*To receive reimbursement, Spouse/Domestic Partner/Child must be covered on your health plan with CCSF, see eligibility on back.

Date Filled	Prescription (RX) No.	Co-payment
		$
		$
		$
		$
		$
		$
		$
		$
		$
Total		$

I certify to the employer that the expenses have not been reimbursed and that I will not seek reimbursement under any other plan or arrangement covering that expense.

Signature _____ Date _____

CCSF Benefits Unit Use Only

Pending:
- Need original prescription receipt printed with insurance information
- Employee/Dependent's name not on receipt
- Missing your signature
- Other:

Denied:
- Not a co-payment
- Unpaid Leave of Absence
- Not eligible
- Unrepresented (non-union)
- Other:

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CLASSIFICATION	ELIGIBLE
FT Classified	Yes
FT/PT Classified School Term Only (6/12) (Working 20+ hours/week)	Yes
PT Classified (Working 20+ hours/week)	Yes