

Administrative Services
Only PO Box 9005, Dept. 251
Lynbrook, NY 11563-9005
800-537-1238 / FAX
855-255-0904 Upload-
asonet.com

**WAPPINGERS CONGRESS OF TEACHERS
WELFARE TRUST FUND
PRESCRIPTION DRUG
REIMBURSEMENT FORM**

Please visit asonet.com and log into your member account for additional plan information, to print claim forms, track your claims and claim history, and to print your ID card, which will have your ASO member ID number.

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	LAST 4 DIGITS OF SOC SEC # OR ASO MEMBER ID #		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
EMAIL ADDRESS HOME TELEPHONE #: CELL PHONE#				

TOTAL AMOUNT SUBMITTED \$ _____ **CALENDAR YEAR:** _____

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Member Signature _____ **Date:** _____

SUMMARY OF BENEFITS

- Effective 1/1/26 for 2025 calendar year services** Up to a maximum of \$350, the Fund reimburses the member the co-payment costs which have been paid within the calendar year for drugs prescribed by a medical doctor, osteopath or dentist.
- Once the \$350 maximum is reached, the Fund will provide an additional reimbursement of 1% of all additional prescription expenses incurred during the same period. Prescriptions must be dispensed by a licensed pharmacist.
 - Prescription services, which are covered are those eligible under your primary prescription plan.

**PLEASE COMPLETE ONLY ONE CLAIM FORM PER FAMILY
AND
ATTACH "ALL COVERED FAMILY MEMBERS CLAIMS SUMMARY"
FROM THE ANTHEM WEBSITE
OR**

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT ASO AT 1-800-537-1238

PRESCRIPTION DRUG REIMBURSEMENT CLAIM FORM 2025

PRESCRIPTION CO-PAYMENT REIMBURSEMENT

Who is eligible.....Member claiming for self and eligible participating dependents. Retirees under the basic plan **are not** eligible.

What is the Benefit....Once annually, up to a maximum of \$350, the Fund reimburses the member the co-payment costs which have been paid within the calendar year for drugs prescribed by a medical doctor, osteopath or dentist. Once the \$350 maximum is reached, the Fund will provide an additional reimbursement of 1% of all additional prescription expenses incurred during the same period. Prescriptions must be dispensed by a licensed pharmacist. Prescription services, which are covered are those eligible under your primary prescription plan.

What is not covered.....There is only one claim per family per calendar year. Individual prescriptions must be accompanied by a pharmacy printout or copy of receipt. Do not submit original receipts because the Fund is not responsible for loss if originals are submitted.

How to File a Claim.....Obtain a prescription co-payment reimbursement claim form from the Fund office. Pharmacy drug printouts may be attached to the claim form in lieu of filling out individual prescription lines proving that the patient's name, date of purchase, prescription number, name of drug, prescription doctor's name, dispensing pharmacy and the cost, or co payment amount of the prescription to the patient is entered. The co-payment amount must be indicated either on the claim form or the pharmacy's print-out. All claim forms **MUST** contain a total dollar amount of the bottom of the claim or it will be returned to you without payment. All items listed will be subject to verification.

When to File a Claim ...Your prescription drug claim **MUST** be submitted in the first quarter following the year charges were made in order to be eligible for coverage. (Example: Covered expenses incurred from 1/1/24 through 12/31/24 can be claimed between 1/1/25 and 3/31/25).

NOTE: The same rules and regulations governing your primary prescription drug plan apply. The Fund does not cover prescription costs incurred by members beyond the amount payable by your primary prescription drug plan. If for some reason you had to pay full price for a prescription, you **MUST** first submit the costs to your primary prescription plan prior to claiming. Do not submit your claim to the Fund unless all costs are backed by proof. Submissions later will **NOT** be reconsidered for payment.

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD THE FUND OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF

MISLEADING INFORMATION CONCERNING ANY FACTUAL MATERIAL THERETO, COMMITS A FRAUD, WHICH IS A CRIME."

PRESCRIPTION DRUG REIMBURSEMENT CLAIM FORM 2025

HOW TO OBTAIN YOUR PRESCRIPTION SUMMARY FOR YOUR PRESCRIPTION REIMBURSEMENT BENEFIT

1. Print the **PRESCRIPTION REIMBURSEMENT** form under the **WELFARE TRUST FUND** tab on the **WCT** website.
2. In order to take advantage of this benefit, you must do one of the following options.

OPTION 1 – (RECOMMENDED)

OPTION 1 will print a prescription summary for your entire family from any of the possible pharmacies that you may have used. It will include **CARELONRx** or any other pharmacies you may have used. **OPTION 1** is the quickest and most efficient way of obtaining this information.

OPTION 1 - LOGIN TO YOUR ANTHEM BLUE CROSS ACCOUNT (ANTHEMBLUECROSS.COM)

- Hover mouse over “CLAIMS AND PAYMENTS” – Click “CLAIMS” from the dropdown menu •
- Scroll down to the gray box – “FILTER” BY CLAIM TYPE
- CLAIM TYPE – PHARMACY (pharmacy box will turn BLUE)
- DATE RANGE - 01/01 - 12/31 of Calendar Year
- ****DON'T APPLY ANY MORE FILTERS ****
- CLICK “APPLY FILTERS” -BLUE BAR AT THE BOTTOM RIGHT
- Click “Export” (directly under the blue “APPLY FILTERS” bar)
- This will send an Excel spreadsheet to your downloads
- Open the downloaded Excel spreadsheet
- Click “FILE” — Scroll down and click “PRINT”
- Change to “LANDSCAPE” orientation
- Change “NO SCALING” to “FIT TO ONE PAGE” if printing
- Print or download the summary to either send via mail, fax or upload to asonet.com

OPTION 2 – CALL AND VISIT YOUR PHARMACIES

If you had prescriptions from CarelonRx or any other local pharmacies you will need to request a summary from each one before submitting for reimbursement.

Member Services - 1-844-951-0622 (dedicated DEHIC member line) or 1-833-270-6383 (pharmacy services)

HOW TO SUBMIT YOUR PRESCRIPTION REIMBURSEMENT FORMS

***** YOU MAY SUBMIT YOUR FORMS VIA REGULAR MAIL, SUBMIT ONLINE OR FAX *****

**Mail summaries AND forms to:
WCT Welfare Trust Fund
% ASO**

**PO Box 9005
Lynbrook, NY 11563
OR**

**Scan and submit summaries online:
Visit asonet.com - log on as a member and select "SUBMIT CLAIM"**

OR

Fax summaries AND forms to: 1-855-255-0904