

**LAY FACULTY ASSOCIATION**

**PRESCRIPTION REIMBURSEMENT PLAN**

Member's Name \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_

School where employed \_\_\_\_\_

**I certify that the patient for whom this claim is made is a covered person (LFA member) under the LFA prescription plan, and that the prescription is for the sole use of said patient.**

Member's signature \_\_\_\_\_ Date \_\_\_\_\_

**Instructions**

Attach copies of the **PRESCRIPTION LABELS** for which you are requesting reimbursement. Be sure the labels indicate the following: Rx Number and date filled, name and address of pharmacy, name of drug (if generic, manufacturer), dosage form, strength and quantity, name of prescribing physician and the total cost of the prescription.

**Mail the form promptly to:**

Mr. Henry Kielkucki  
588 North State Road  
Briarcliff Manor, NY 10510

The maximum reimbursement under this plan is fifty dollars (\$50.00) under any single **academic year**.

**For Union Use Only**

Amount Approved \_\_\_\_\_

Approved By: \_\_\_\_\_ Date Approved \_\_\_\_\_

Date sent to treasurer for reimbursement \_\_\_\_\_