



# Total Health Care Prescription Reimbursement Form

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

**X**

EMPLOYEE SIGNATURE VERIFICATION (Receipts will not be processed without signature)

**STEP 1:** Please thoroughly complete the reimbursement form only for eligible prescription expenses incurred during 2018. Each prescription with an out-of-pocket cost of \$15 or more will be reimbursed \$5. You must be a participant in the Total Health Care plan at the time the expense was incurred. The incurred date of the expense is the date of service. This form is for prescription co-pay reimbursements payable by Rochester College only.

**STEP 2:** Appropriate receipts (original or photocopy) **MUST** be stapled to the form in order to insure proper reimbursement. (SEE REVERSE SIDE FOR ACCEPABLE RECEIPT INFORMATION)

**STEP 3:** Submit form and attached receipts to Ginny May - Director of Human Resources. Please note the receipt submission and refund schedule on the reverse side of this form.

DATE OF SERVICE	DRUG STORE	NAME OF DRUG	PATIENT NAME	OUT-OF-POCKET COST	EXPECTED REIMBURSEMENT
/ /				\$	\$
/ /				\$	\$
/ /				\$	\$
/ /				\$	\$
/ /				\$	\$
/ /				\$	\$
/ /				\$	\$
/ /				\$	\$
/ /				\$	\$
/ /				\$	\$



# Rx Co-Pay Reimbursement

Rochester College employees who are covered under the Total Health Care plan during 2018 are eligible to receive a \$5 reimbursement for any prescription co-pay greater than \$15.

Reimbursements are considered earned income and will be dispersed through your payroll as a taxable employee benefit. If you have enrolled in a Flexible Spending Account for 2018, Rx receipts submitted for reimbursement to the College do not affect your FSA.

Acceptable receipts should include all viable information, including patient name, Rx #, doctor, quantity, and amount. A sample receipt should look like the following (example from Walgreens):

**ERNIE MAY**  
1334 Pembroke \*\*verify Address\*\*, Oxford, MI 48371  
(248)961-4954  
**RX # 1050999-05675**      DATE: 11/15/16

**COREG CR 20MG CAPSULES**  
QTY: 90      NO REFILLS - DR. AUTH REQUIRED  
Refill      NDC:00007-3371-13  
Retail Price: \$1001.89      Your Insurance Saved You: \$961.89      \$ **40.00**

S. KAZZIHA, MD      PLAN: NAVTS  
MFG: GLAXO SMITH KLINE      GROUP# OCM  
KAS/KAS/KAS/DEE/KAS      CLAIM REF# 2820174611162B

*Walgreens*      450 N PARK BLVD LAKE ORION, MI 48362      Customer  
PH: (248)814-7315      Receipt

Printed reports provided by your drug store are also acceptable. Cash register receipts will not be accepted.

In order to receive reimbursement, please complete and sign the **THC Rx Reimbursement Form**, and staple all receipts (originals or photocopies) to the form. Please use additional forms, if needed. Forms and receipts can be submitted to my office at any time. For accounting purposes, the following schedule must be adhered to – THERE WILL BE NO EXCEPTIONS:

- **Receipts dated June 1 – December 31, 2018** must be submitted by January 31, 2019  
Reimbursement will be posted to payroll dated February 15, 2019
- **Receipts dated January 1 – May 31, 2019** must be submitted by June 30, 2019  
Reimbursement will be posted to payroll dated July 15, 2019