THE NATIONAL ASBESTOS WORKERS MEDICAL FUND

7130 COLUMBIA GATEWAY DRIVE, SUITE A, COLUMBIA MARYLAND 21046
Toll Free Number (800) 386-3632 Telephone (410) 872-9500

DIRECT PRESCRIPTION REIMBURSEMENT FORM

Please be advised a separate form must be submitted for each family member

INSTRUCTIONS

This form should be used **ONLY** for listing prescription drugs. List each prescription separately. (Medicine which can be purchased without a doctor's prescription **IS NOT COVERED** even if a doctor has prescribed or recommended its use).
ATTACH ALL DRUG BILLS ENTERED TO THIS FORM.

To Be Completed By Employee (Please Print Clearly) If this is a new address, please check here ☐

Name and Home Address of Employee (Print)
Name: _____ Local No. _____
Soc. Sec. No. _____

No. Street City State Zip

Was illness or injury due, in any way,
To your occupation?
☐ Yes ☐ No If "Yes" Explain:

Dependent's Information: (Complete Only If Claim is for Dependent)

Name of Dependent:	Date of Birth:	Relationship:

PRESCRIPTION DRUGS

PLEASE PRINT

Date Purchased	Prescription Number	Name of Drug	Diagnosis – Nature of Illness or Injury	Charge	
				$	
			Total	$	

FORM MUST BE COMPLETED AND SIGNED BEFORE SENDING TO FUND OFFICE

Authorization and Certification

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release any and all information with respect to this claim which may be necessary to determine any amount payable. I certify that the above statements and information are correct and that none of the expenses listed herein results from any occupational illness or injury.

Signed at _____ on _____ by _____
City and State Mo. Day Yr Signature of Employee

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