(TOMGC)

TOWNSHIP OF MONROE
RETIREE MEDICAL/PRESCRIPTION REIMBURSEMENT CLAIM FORM

RETIREE INFORMATION					
NAME:	LAST	FIRST	MIDDLE	HOME PHONE NUMBER	
ADDRESS:	STREET	APARTMENT#	CITY	STATE	ZIP CODE
SS# / ID#:		HORIZON DIRECT 10 SUBSCRIBER ID:			

DEPENDENT INFORMATION				
NAME:	LAST	FIRST	MIDDLE	RELATIONSHIP
NAME:	LAST	FIRST	MIDDLE	RELATIONSHIP :
NAME:	LAST	FIRST	MIDDLE	RELATIONSHIP

INSTRUCTIONS

1) For Medical/Prescription Reimbursement Claims, attach copies of the Explanation of Benefits (EOB) issued by Horizon Blue Cross Blue Shield (BCBS) NJ Direct and/or Retail Pharmacy Customer Receipt, and/or Invoices or Claims & Balances Report issued by Express Scripts to establish amount(s) paid and eligible for Plan Difference reimbursement.

2) Submit This Form To:
INSURANCE DESIGN ADMINISTRATORS
P.O. BOX 690
OAKLAND, NJ 07436
CUSTOMER SERVICE # - (800) 225-1345
FAX # - (201) 337-1391

EXPENSES

MEDICAL/PRESCRIPTION PROVIDER	DATE RANGE EXPENSES INCURRED	AMOUNT PAID	AMOUNT OF CLAIM
		TOTAL AMOUNT	$

A. I am submitting this Form with the required documentation, Horizon Blue Cross Blue Shield (BCBS) NJ Direct EOB, Proof of Payment and/or Retail Pharmacy Customer Receipt and/or Express Scripts Invoices or Claims & Balances Report.

RETIREE CERTIFICATION AND SIGNATURE

I Hereby Certify That:

1. The amount of the Claim is the difference between the current Horizon Blue Cross Blue Shield (BCBS) NJ Direct and/or Express Scripts, whichever is applicable, and the prior Township of Monroe Plan, minus the Retiree responsibility, is owed to me, and

2. I have not received, and am not eligible to receive, any type of reimbursement or payment other than the amount noted as the difference in Plan provisions noted above, if any.

I CERTIFY THAT THE FOREGOING STATEMENTS ARE TRUE. I AM AWARE THAT IF ANY OF THE FOREGOING STATEMENTS MADE BY ME ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT.

SIGNATURE_____ **DATE**_____