

City College of San Francisco

S / h Prescription Drug Co-Payment Reimbursement Form

Please read the Rules & Guidelines printed on the back before completing this form
(Attach original receipts/documents to the back)

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& K L O G U H Q

*To receive reimbursement, Spouse/Domestic Partner/Child must be covered on your health plan with CCSF, see eligibility on back.

Date Filled	Prescription (RX) No.	Co-payment
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
Total		\$

I certify to the employer that the expenses have not been reimbursed and that I will not seek

CLASSIFICATION	ELIGIBLE
FT Classified	Yes
FT/PT Classified School Term Only (62) (Working 20+ hours/week)	Yes
PT Classified (Working 20+ hours/week)	Yes
