1199SEIU Benefit Funds

PO Box 1007, New York, NY 10108-1007
Tel: (646) 473-9200

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

TO BE COMPLETED BY MEMBER

PART (A): MEMBER INFORMATION

1. MEMBER'S BENEFIT ID NUMBER

2. MEMBER'S NAME AND ADDRESS

Last First

No. and Street Apt. No.

City State Zip Code

( )
Telephone No.

3. MEMBER'S EMPLOYER

3a. Job Title | 4. DATE OF BIRTH Month Day Year | SEX

5. CHECK ONE BOX ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

6a. Are you or your dependent/spouse covered under any other group plan? ☐ Yes ☐ No

6b. If yes, complete:

Name of person covered Relationship

Name and address of person's employer

6c. Plan name and number

6d. Effective date

PART (B): PATIENT INFORMATION

1. PATIENT'S NAME (First Name, middle initial, last name)

2. PATIENT'S DATE OF BIRTH Month Day Year

3. PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Child ☐ Other: _____ *(please specify)*

4. PATIENT'S SEX ☐ Male ☐ Female

5. IS PATIENT A DEPENDENT AGE 19 OR OVER? ☐ Yes ☐ No
IF YES, PART (D) DEPENDENT CHILD INFORMATION ON REVERSE SIDE MUST BE COMPLETED.

6a. WAS INJURY OR CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO
B. ACCIDENT ☐ AUTO ☐ OTHER

6b. IF ACCIDENT, GIVE DATE

6c. IS OR WILL LEGAL ACTION BE TAKEN? ☐ YES ☐ NO

6d. LAWYER'S NAME AND ADDRESS, IF ANY:

7. I AUTHORIZE THE RELEASE TO OR BY NBF OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

▶ *Signature of Member of Spouse* *Dated*

8. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

▶ *Signed* *Dated*

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

PART (C): PHYSICIAN OR SUPPLIER INFORMATION–Please complete all items

1. Date of First Treatment for Condition

2. Is this an initial consultation? ☐ Yes ☐ No

3. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No

4. For service related to hospitalization, give hospitalization dates: Admitted Discharged
Name of Hospital

5. Name and Address of Referring Physician

6. Will any claim for the services below be filed with any other insurance carrier or benefit provider? ☐ Yes ☐ No If yes, please specify

6a. NPI #

7. Preventive checkup? ☐ Yes ☐ No

Diagnosis or nature of illness or injury (if diagnosis code other than ICD9*, give name) — ICD9 CODE
1. Primary 3. Secondary
2. Secondary 4. Secondary

8. REPORT OF SERVICES (or attach itemized bill).

Date of Services	Place of Services†	Description of Surgical or Medical Services Rendered	Procedure Code, if used (If code other than CPT4 * * used, give name)	Charges

† DO-Doctor's Office IH-Inpatient Hospital NH-Nursing Home
H-Patient's Home OH-Outpatient Hospital OL-Other Locations

*ICD9-International Classification of Diseases

* *CPT-Current Procedural Terminology (current edition)

TOTAL CHARGES $ _____

AMOUNT PAID $ _____

BALANCE DUE $ _____

9. Physician's name (print) _____ 10. Specialty _____

11. Physician's signature _____ 12. Date _____

13. Street address _____ City _____ State _____ Zip Code _____

14. Telephone ( ) _____ 15. Indv. Practitioner's SS# / / / / / / / / / NPI # / / / / / / / / / /

NOTE: If you are accepting an assignment of benefits, please complete Item No. 15 to avoid delay in payment.

PART (D): DEPENDENT CHILD INFORMATION

This part must be completed each time a claim is submitted for a dependent child age 19-23.

DEPENDENT

(print) Last Name Init. First Name

Date of Birth Social Security No.

Is the dependent employed? If yes, give name and address of dependent's employer:

Dependent's Employer Address

Dependent is employed ☐ Full Time ☐ Part Time

My dependent child listed above is not married, is principally dependent upon me for maintenance and support, is under 23 years of age, and is my natural or adopted child.

Member's Signature ►

Date

PART (E): CLAIM FILING INSTRUCTIONS

Mail this CLAIM FORM promptly. Follow these instructions to avoid delay.

1. Member must complete Parts A and B of Claim Form.
2. Complete Part D if claim is for a dependent child age *19-23.*
3. Have your physician or supplier complete Part C.
4. The completed Claim Form should be mailed to the Fund within *30 days* of the date the services were provided.
5. A separate claim form must be completed for *each patient.*
6. If the Fund is not your primary insurer, you must attach a copy of the payment voucher from the other plan.

Mail your form to: **1199SEIU Benefit Funds**
Times Square Station
PO Box 1007
New York, NY 10108-1007