DOCTORS COUNCIL HEALTHCARE COST REIMBURSEMENT BENEFIT CLAIM FORM

Please check the appropriate box: **ACTIVE WELFARE FUND** **RETIREE WELFARE FUND** **BENEFIT PLAN**

MAIL TO:
Administrative Services Only, Inc
PO Box 9005
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238

Effective January 1, 2011
Welfare Fund Members: Annual Family Maximum is $1,000 for full time Members and $500 for part time members per plan year
Plan A: Full time members $300/ $600 for single/ family
Plan B: $1,000 per family
Retired Members: Annual Family is $1,000 per plan year

PATIENT INFORMATION

PATIENT NAME	BIRTH DATE	MALE / FEMALE	RELATIONSHIP TO MEMBER: SELF CHILD SPOUSE/DOMESTIC PARTNER

NAME ALL BENEFIT PLANS COVERING THIS PATIENT

IS THIS PATIENT COVERED BY A:

(1) GROUP MEDICAL PLAN YES NO (2) GROUP DENTAL PLAN YES NO (3) GROUP VISION PLAN YES NO

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	MALE FEMALE		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
U.S. SOCIAL SECURITY NO.		DAYTIME TELEPHONE NUMBER		
EVENING TELEPHONE NUMBER		AGENCY OR DEPARTMENT		
JOB TITLE	WORK LOCATION	FULL-TIME PART-TIME SESSIONAL		

ENROLLMENT STATEMENT

This benefit is only available to members covered under a group health benefit plan. This benefit is not available if you opted out of the group health benefit plan offered through your employer and are not covered under another group health benefit plan. If you are covered under a plan purchased on an individual basis, including an ACA Exchange plan, this benefit is not available to you.

I am enrolled in the group health benefit plan provided by my employer

I am enrolled in a group benefit plan provided by my spouse's employer

NOTE: **Please submit a copy of your group health plan ID card with this reimbursement claim.**

IMPORTANT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.

MEMBER SIGNATURE

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED. I HEREBY CERTIFY THAT I AM ENROLLED IN A GROUP HEALTH PLAN THAT MEETS MINIMUM VALUE STANDARDS UNDER THE AFFORDABLE CARE ACT. I AM SUBMITING A COPY OF MY GROUP HEALTH PLAN ID CARD FOR THAT COVERAGE ALONG WITH THIS REIMBURSEMENT CLAIM.

REIMBURSEMENTS ARE PAYABLE TO MEMBERS ONLY

_______________________________________ SIGNATURE OF MEMBER

_______________________ DATE

Covered Expenses Include:

Medical and Hospital Deductibles and Co-Payments under Medicare and /or you group medical/ surgical and hospital insurers.

Prescription Drug Deductibles or Co-Payments under your group medical/ surgical and hospital insurers.

Charges incurred for health services covered in a member's existing coverages that exceed the reimbursement received, (including services covered under Doctors Council Welfare Fund). Premiums for Medicare Part "B" may reimbursed with proof of reimbursement from the NYC Health Benefit Program; Medigap and other out-of-pocket healthcare coverage/ expenses.

How to File a Claim:

1. **Complete the claim form and attach ALL COPIES of the itemized bills for the expense incurred and the corresponding explanation of benefits vouchers FROM ALL GROUP HEALTH INSURANCE PLANS covering the patient.**

2. Please submit a copy of your group health plan ID card.

3. File a separate claim form for each family member.

4. Do not submit your claim until the end of the plan year unless you have already met the full amount of the benefit.

5. **For Members of Doctors Council Welfare Fund and Doctors Council Retiree Welfare Fund:**

   All claims for benefits must postmarked no later than **June 30th of the following Plan year (July 1 – June 30)** in which the expense was incurred.

   For Members of Doctors Council Benefit Plan:

   All claims for benefits must postmarked no later than **December 31 of the following Plan year (January 1 – December 31)**.

FAILURE TO FILE REQUIRED DOCUMENTATION AND/ OR SIGN EACH CLAIM FORM WILL CAUSE DELAY IN THE PROCESSING OF YOUR CLAIM, AND MAY CAUSE A DENIAL OF YOUR CLAIM.