

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

Please print clearly in blue or black ink.

PART A: MEMBER INFORMATION

Member's full name		Member ID #		
Address		City	State	Zip code
Primary telephone		Date of birth		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Name of employer		Date of hire		
Current marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally separated				
Do you or your dependent child(ren) or spouse have other health insurance coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Relationship to member: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent child				
If "yes," name of person covered				
Name of insurance plan		Policy/Group number		
Insurance plan telephone		Effective date of coverage		

PART B: PATIENT INFORMATION

Patient's full name		Patient's date of birth		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent child <input type="checkbox"/> Other: _____ (Please specify)				
Is patient a dependent who is age 19 or older? <input type="checkbox"/> No <input type="checkbox"/> Yes If "yes," Part C: Young Adult Information must be completed (see below).				
Was injury or condition related to:				
A. Patient's employment: <input type="checkbox"/> No <input type="checkbox"/> Yes B. Accident: <input type="checkbox"/> Auto <input type="checkbox"/> Other: _____ (Please specify)				
Has legal action been taken, or will it be? <input type="checkbox"/> No <input type="checkbox"/> Yes				
If accident, give date accident occurred				
If "yes," give lawyer's full name		Lawyer's telephone number		
Address		City	State	Zip code

I authorize the release to or by the Funds of any medical information necessary to process this claim.

X _____
Patient's signature Date

I authorize payment of medical benefits to the undersigned physician or supplier for the services described in Part D.

X _____
Member's signature Date

PART C: YOUNG ADULT INFORMATION – This part must be completed each time a claim is submitted for a dependent child age 19 to 26.

Dependent's full name		Dependent's Social Security #		
Dependent's date of birth		Is dependent employed? <input type="checkbox"/> No <input type="checkbox"/> Yes If "yes," give name and address of employer:		
Name of dependent's employer		<input type="checkbox"/> Full time <input type="checkbox"/> Part time		
Address		City	State	Zip code

My dependent child listed on previous page is 19 to 26 years of age and is my biological or adopted child.

X

Member's signature

Date

X

Dependent's signature

Date

PART D: PHYSICIAN OR SUPPLIER INFORMATION – Please have physician or supplier complete all items.

Was this an initial consultation? No Yes

Date of first treatment for condition

Is condition due to injury or illness arising out of patient's employment? No Yes

For service related to hospitalization, give hospitalization dates:

Date admitted

Date discharged

Name of hospital

Address of hospital

City

State

Zip code

Will any claim for the services reported below be filed with any other insurance carrier or benefit provider? No Yes

Preventive checkup? No Yes

If "yes," please specify

Diagnosis or nature of injury or illness (if diagnosis code is other than ICD-10,* give name):

1. Primary

2. Secondary

3. Secondary

4. Secondary

ICD-10 code

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 CPT-4** used, give name)	Charges

† DO – Doctor's office

IH – Inpatient hospital

NH – Nursing home

TOTAL CHARGES \$ _____

H – Patient's home

OH – Outpatient hospital

OL – Other location

AMOUNT PAID \$ _____

*ICD-10 – International Classification of Diseases

**CPT – Current Procedural Terminology (current condition)

BALANCE DUE \$ _____

Name of referring physician

Specialty

Address

City

State

Zip code

Telephone

Individual practitioner's Social Security #

NPI #

X

Physician's signature

Date

NOTE: If you are accepting an assignment of benefits, please supply individual practitioner's SS# to avoid delay in payment.

PART E: CLAIM FILING INSTRUCTIONS – Mail this claim form promptly. Follow these directions to avoid delay in payment.

- Member must complete Parts A and B of claim form.
- Complete Part C if claim is for your young adult dependent (age 19 to 26).
- Have your physician or supplier complete Part D.
- The completed form should be mailed to the Benefit Funds within 30 days of the date the services were provided.
- A separate claim form must be completed for each patient.
- If the Benefit Fund is not your primary insurer, you must attach a copy of the payment voucher from the primary insurance plan.

**MAIL YOUR FORM TO: 1199SEIU BENEFIT FUNDS
PO BOX 1007
NEW YORK, NY 10108-1007**