**Please read reverse side for limitations and required documentation needed to submit a claim**
**Claims must be filed within 1 year of the date of service or payment by health plan, whichever is later**

# SHIP Claim Form

**UFT/RTC Supplemental Health Insurance Program (SHIP)**

**Mail Claim Form to:** **SHIP**
**P.O. Box 390**
**Bowling Green Station**
**New York, NY 10274-0390**

**Telephone: (212) 228-9060**

| Member's Last Name | | First Name | | |
|---|---|---|---|---|
| | | | | |
| Patient's Last Name (if member write "Same") | | First Name | | |
| | | | | |
| Address | Apt.# | City | State | Zip Code |
| | | | | |
| Member's Social Security No. | Patient's Social Security No. | | Telephone# | |
| – – | – – | | | |

| Enter Patient's Health Plan name below | Patient's Birth Date (Month-Day-Year) | Is Patient on Medicare? (check box) | | | |
|---|---|---|---|---|---|
| | | No: | | Yes: | |

**Member (or Spouse if claim is for spouse) Sign Below:**

X Date

**Instructions for filing a claim:**
**Please submit a separate Claim Form for each different SHIP Claim Benefit.**

**Signature: (If Member deceased/incapacitated please call SHIP at above telephone number)**

**Claim Benefit 1 to 14: Benefits for ALL Members, Claim Benefit A to D: Limited by Health Plan**

| Claim Benefit (for ALL Members) | Amount or X | Claim Benefit (for ALL Members) | Amount or X |
|---|---|---|---|
| 1. Accidental Death & Dismember. | | 11. Orthotics | |
| 2. Ambulance/Ambulette | | 12. Podiatry | |
| 3. Blood Bank | | 13. Psychiatric Hospitalization | |
| 4. Dental Stipend (see back) | | 14. Surgical Stockings | |
| 5. Durable Medical Equipment | | Claim Benefit (Limited by Plan) | Amount or X |
| 6. Hairpieces or Wig | | A. Chiropractor | |
| 7. Hearing Aid | | B. Prescriptions Drugs | |
| 8. Hospital Deductible (a. or b.) | | C. Private Duty Nursing | |
| 9. Nurse's/Home Health Aide(s) | | D. Surgery/Anesthesia | |
| 10. Orthopedic Shoes | | | |

| Do Not Write In Area Below (SHIP use only) | | | Name/Initial | Date |
|---|---|---|---|---|
| Date Received: | | Claims Processor: | | |
| SHIP Plan: | | Approved By: | | |
| Effective Date: | | Rejected By: | | |
| Reason for Rejection: | | | | |

**Photocopies of this Claim Form are accepted.**

SHIP Claim Form Revised January 2010

x

**SHIP is a reimbursement program and will NOT pay providers directly. All claims payable to Member.**
**Claims MUST be filed within 1 year from date of service or date of payment by health plan(s), whichever is later.**

**SHIP coordination of benefits with other Health Insurance Plan(s) Policy.**
CSA/RSSA: If spouse is covered by CSA/RSSA, spouse must file claims with CSA first and UFT member must file claims with SHIP first.
ALL health plan(s) are primary to SHIP coverage , except NYSUT Catastrophic, which is secondary to SHIP.
**Notice: Member/spouse is NOT entitled to collect more than 100% reimbursement for any service or purchase.**

**Claim procedures: Please submit a separate Claim Form for each different SHIP Claim Benefit.**
Claim Form MUST be signed and completed, all questions MUST be answered.
Copies of required documents accepted, do not send originals if possible because they will not be returned.
Proof of payment: cancelled check, check printed on bank statement, credit card receipt or statement or receipt from vendor, etc.
**Listed below are the document(s) required and limitations to process a claim, see SHIP Booklet for further details.**

## Claim Benefit documents/limitations requirements. Item a. Completed SHIP Claim Form required for ALL claims.

**1. Accidental Death & Dismemberment**
b. Proof of accidental death/dismemberment
Limitation: Benefits are payable up to age 80.

**2. Ambulance/Ambulette ($300 Annual limit)**
b. Copy of invoice/bill with proof of payment
c. Copy of primary/secondary insurance coverage (such as Medicare, GHI, HIP, etc. for Ambulance only)

**3. Blood Bank ($500 Annual limit)**
b. Copy of invoice/bill with proof of payment
c. Copy of primary/secondary insurance coverage

**4. Dental Stipend ($200 once every 2 or more years )**
b. Copy of CIGNA Explanation of Dental Benefits Summary (or other UFT Welfare Fund dental carrier if applicable)
c. Copy of proof of payment
**Limitation: One Dental Claim every 2 calendar years.**
Sign statement below if your dental claim is for less than $200.
**I accept the amount submitted and understand I cannot submit another dental claim for 2 years.**

**Signature** **Date**

**5. Durable Medical Equipment ($100 Annual limit)**
b. Copy of invoice/bill with proof of payment
c. Copy of primary/secondary insurance coverage
Limitation: Primary/secondary Ins. MUST partially cover or apply deductible for SHIP to cover item. 1 claim submission per year.

**6. Hairpiece or Wig ($300 maximum per occurance)**
b. Physician's statement explaining reason and ailment
c. Copy of invoice/bill with proof of payment
Limitation: Hair loss due to chemotherapy or radiation therapy.

**7. Hearing Aid ($500 once every 3 or more years)**
b. Physician's statement recommending need
c. Copy of invoice/bill with proof of payment
Limitation: Hearing Aid once every 3 or more "service" years.
Note: UFT Welfare Fund also provides hearing aid benefit

**8. Hospitalization Deductible: a.In-Patient ($300 per stay, $750 Annual limit), b.Emergency Room (1 visit, $50 max.)**
b. Copy of hospital bill showing dates of hospitalization
c. Copy of invoice/bill with proof of payment

**9. Nurse's Aide(s) ($20,000 Lifetime maximum)**
b. Physician's statement explaining reason and ailment
c. Proof of hospital stay of 3 or more days
d. Copy of invoice showing service period (from nursing agency or from state certified nursing aide) with proof of payment
Limitation: SHIP covers 50% of the cost of "at-home" nursing aides within 10 days of discharge from hospital stay of 3 days or more.
Limitation: Benefit is NOT available for the first year of enrollment.

**10. Orthopedic Shoes ($200 Annual limit, $1,000 Lifetime)**
b. Physician's statement recommending need
c. Copy of invoice/bill with proof of payment
Limitation: Must be "Custom made" or "Customized"

**11. Orthotics ($200 Annual limit, $1,000 Lifetime)**
Same documentation & limitation as 10. Orthopedic Shoes

**12. Podiatry ($10 per visit, 4 visits Annual limit)**
b. Copy of invoice/bill with proof of payment
c. Copy of primary/secondary insurance coverage (such as Medicare, GHI, HIP, etc.)
Limitation: 1 claim submission per calendar year.

**13. Psychiatric Hospitalization ($2,500 per stay maximum)**
b. Proof of 30 days coverage by primary/secondary ins.
c. Copy of invoice/bill with proof of payment

**14. Surgical Stockings ($200 Annual limit, $1,000 Lifetime)**
b. Physician's statement recommending need (first claim only)
c. Copy of invoice/bill with proof of payment
Limitation: 1 claim submission per calendar year.

---

**Claim Benefit A. to D. Limited by Health Plan(s)**

**A. Chiropractor ($10 per visit, 8 visits Annual limit)**
b. Copy of invoice/bill with proof of payment
c. Copy of primary/secondary insurance coverage (such as Medicare, GHI, HIP, etc.)
Limitation: 1 claim submission per calendar year.
**Health Plan Limit: benefit for HIP/HMO plan only.**

**B. Prescription Drugs ($1,000 Annual limit)**
**(benefit includes both mail-order and pharmacy)**
b. GHI: copy of 4 quarterly Express Scripts statements or HIP/HMO: copy of annual prescription drug statement(s).
AFTER a $500 annual deductible, SHIP will reimburse 100% of total prescription cost up to a $1,000 ANNUAL benefit. Prescription drugs MUST be partially covered by your primary/secondary insurance to be eligible for benefit. Limitation: 1 claim submission per calendar year. You MUST wait until you receive annual drug statement(s) unless you reach $1,000 maximum benefit prior to year end or until you become Medicare eligible.
**Health Plan Limit: Medicare eligible member NOT eligible for benefit.**

**C. Private Duty Nursing in Hospital**
b. Physician's statement explaining reason and ailment
c. Copy of invoice/bill with proof of payment
d. Copy of primary/secondary insurance coverage
Limitation: GHI: GHI must cover for any SHIP reimbursement.
Health Plan: Benefit varies depending on plan, see SHIP Booklet.

**D. Surgery/Anesthesia ($5,000 per Procedure maximum)**
b. Copy of invoice/bill with proof of payment
c. Copy of primary/secondary insurance coverage such as GHI
Health Plan: Benefit varies depending on plan, see SHIP Booklet.