# 1199SEIU Benefit Funds

PO Box 1007, New York, NY 10108-1007 • www.1199SEIUBenefits.org
Tel (646) 473-7160 • Outside NYC area codes: (800) 575-7771


## MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

**PART A: MEMBER INFORMATION**

Member ID #: _____ Member's full name: _____

Address: _____ City: _____ State: _____ Zip code: _____

Telephone: ( _____ ) _____ Date of birth: _____ (Month) / _____ (Day) / _____ (Year) Sex: ❑ M ❑ F

Name of employer: _____ Date of hire: _____ (Month) / _____ (Day) / _____ (Year)

Current marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally separated

Do you or your dependent child(ren) or spouse have other health insurance coverage? ❑ Yes ❑ No

If yes, name of person covered: _____

Relationship to member: ❑ Self ❑ Spouse ❑ Dependent child

Name of insurance plan: _____

Policy/Group number: _____ Insurance plan telephone: ( _____ ) _____

Effective date of coverage: _____ (Month) / _____ (Day) / _____ (Year)

**PART B: PATIENT INFORMATION**

Patient's full name: _____

Patient's date of birth: _____ (Month) / _____ (Day) / _____ (Year) Sex: ❑ M ❑ F

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other _____ (Please specify)

Is patient a dependent age 19 or over? ❑ Yes ❑ No If yes, Part C: Young Adult Information must be completed (see below).

Was injury or condition related to:

**A.** Patient's employment: ❑ Yes ❑ No **B.** Accident: ❑ Auto ❑ Other _____ (Please specify)

If accident, give date: _____ (Month) / _____ (Day) / _____ (Year) Has legal action been taken, or will it be? ❑ Yes ❑ No

Lawyer's name: _____

Address: _____ City: _____ State: _____ Zip code: _____

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

**Patient's signature X** _____ **Date:** _____

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

**Member's signature X** _____ **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 date of birth: _____ (Month) / _____ (Day) / _____ (Year) Social Security #: _____-_____ - _____

Is the dependent employed? ❑ Yes ❑ No If Yes, give name and address of employer:

Name of employer: _____ ❑ Full time ❑ Part time

Address: _____ City: _____ State: _____ Zip code: _____

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

**Member's signature X** _____ **Date:** _____

**Dependent's signature X** _____ **Date:** _____

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

Date of first treatment for condition: _____ (Month) / _____ (Day) / _____ (Year) Is this an initial consultation? ❑ Yes ❑ No

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

For service related to hospitalization, give hospitalization dates:

Admitted: _____ (Month) / _____ (Day) / _____ (Year) Discharged: _____ (Month) / _____ (Day) / _____ (Year)

Name of hospital: _____

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

If yes, please specify: _____

Preventive check-up? ❑ Yes ❑ No

Diagnosis or nature of illness or injury (if diagnosis code is other than ICD9,* give name):

1. Primary: _____ 2. Secondary: _____

3. Secondary: _____ 4. Secondary: _____

ICD9 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
H-Patient's Home OH-Outpatient Hospital OL-Other Location
*ICD9-International Classification of Diseases **CPT-Current Procedural Terminology (current edition)

TOTAL CHARGES $ _____
AMOUNT PAID $ _____
BALANCE DUE $ _____

Name of referring physician: _____

Specialty: _____ Telephone: ( _____ ) _____

Address: _____ City: _____ State: _____ Zip code: _____

Individual practitioner Social Security #: _____ NPI #: _____

**Physician's signature X** _____ **Date:** _____

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

**PART E: CLAIM FILING INSTRUCTIONS -** Mail this claim form promptly. Follow these instructions to avoid delay.

- 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 plan.

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