1199SEIU Benefit Funds

330 West 42nd Street • New York, NY 10036-6977 • Tel: (646) 473-7160 • Outside NYC area codes: (800) 575-7771 • www.1199SEIUBenefits.org

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: ☐ M ☐ F

Name of employer _____ Date of hire _____

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

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

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 _____

PART B: PATIENT INFORMATION

Patient's full name _____ Patient's date of birth _____ Sex: ☐ M ☐ F

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

Is patient a dependent who is age 19 or older? ☐ No ☐ Yes If "yes," Part C: Young Adult Information must be completed (see below).

Was injury or condition related to:

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

If accident, give date accident occurred _____ Has legal action been taken, or will it be? ☐ No ☐ Yes

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? ☐ No ☐ Yes If "yes," give name and address of employer:

Name of dependent's employer _____ ☐ Full time ☐ 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

H – Patient's home OH – Outpatient hospital OL – Other location

*ICD-10 – International Classification of Diseases **CPT – Current Procedural Terminology (current condition)

TOTAL CHARGES $ _____

AMOUNT PAID $ _____

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