1199SEIU Benefit Funds

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

STATEMENT FOR MEDICAL CLAIM REIMBURSEMENT

Please print clearly in blue or black ink, or complete online.

Follow these directions to avoid a delay in payment:

- You must have your physician/hospital or supplier complete, sign and date this form.
- A separate claim form must be completed for each patient.
- You must submit the completed form to the Benefit Fund within 30 days of the date the service(s) were provided.
- If the Benefit Fund is not your primary insurer, you must submit a copy of the payment voucher from the primary insurance plan.
- After your physician/hospital or supplier has completed this form, you must scan or take a photo of it. Then upload it to My Account at **www.1199SEIUBenefits.org** to have these costs reviewed. Please note that additional documentation may also be required.

MEMBER'S FULL NAME _____ MEMBER ID # _____

PATIENT'S FULL NAME _____ PATIENT'S DATE OF BIRTH (MM/DD/YYYY) _____

Is the condition due to an injury or illness arising from the patient's employment? ☐ No ☐ Yes

Will any claim for the service(s) you report below be filed with another insurance carrier or benefit provider? ☐No ☐Yes

If "Yes," please specify: _____

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

1. PRIMARY _____ 2. SECONDARY _____ 3. SECONDARY _____ 4. SECONDARY _____

Report of Services (or attach itemized bill):

Date of Service (MM/DD/YYYY)	Place of Service †	Description of Surgical or Medical Service Rendered	Procedure Code, If Used (if code is other than CPT-4, provide name)	Charge
				$
				$
				$

† DO – Doctor's office IH – Inpatient hospital NH – Nursing home
H – Patient's home OH – Outpatient hospital OL – Other location

Total charges: $_____
Amount paid: $_____
Balance due: $_____

PHYSICIAN/HOSPITAL OR SUPPLIER _____ SPECIALTY _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ INDIVIDUAL PRACTITIONER'S SOCIAL SECURITY # _____ NPI # _____

NOTE: If you are accepting an assignment of benefits, provide the individual practitioner's Social Security # to avoid a delay in payment.

X _____

PHYSICIAN'S OR SUPPLIER'S SIGNATURE **DATE (MM/DD/YYYY)**

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