

DOCTORS COUNCIL HEALTHCARE COST REIMBURSEMENT BENEFIT CLAIM FORM

Please check the appropriate box: ACTIVE WELFARE FUND RETIREE WELFARE FUND BENEFIT PLAN

MAIL TO:

Administrative Services Only, Inc

PO Box 9005

Lynbrook, NY 11563-9005

516-396-5500 / 800-537-1238

Covered Expenses include: Medical and Hospital Deductibles and Co-Payments under Medicare and /or your group medical/surgical and hospital insurers. Prescription Drug Deductibles or Co-Payments under your group medical/surgical and hospital insurers. Charges incurred for health services covered in a member's existing coverages that exceed the reimbursement received, (including services covered under Doctors Council Welfare Fund). Premiums for Medicare Part "B", Medigap, and other out-of-pocket healthcare coverage.

PATIENT INFORMATION

PATIENT NAME	BIRTH DATE	MALE <input type="checkbox"/>	RELATIONSHIP TO MEMBER		
		FEMALE	SELF	SPOUSE	CHILD
NAME ALL BENEFIT PLANS COVERING THIS PATIENT					

IS THIS PATIENT COVERED BY A:

(1) MEDICAL PLAN YES NO (2) DENTAL PLAN YES NO (3) VISION PLAN YES NO

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	MALE	FEMALE	
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
U.S. SOCIAL SECURITY NO. 	DAYTIME TELEPHONE NUMBER			
EVENING TELEPHONE NUMBER	AGENCY OR DEPARTMENT			
JOB TITLE	WORK LOCATION	FULL-TIME	PART-TIME	SESSIONAL

HOW TO FILE A CLAIM

- (1) Complete the claim form and attach all copies of the itemized bills for the expenses incurred and the corresponding explanation of benefits vouchers FROM ALL HEALTH INSURANCE PLANS covering the patient
- (2) File a separate claim form for each family member.
- (3) Do not submit your claim until the end of the plan year unless you have already met the full amount of the benefit.
- (4) For Members of Doctors Council Welfare Fund and Doctors Council Retiree Welfare Fund: All claims for benefits must be postmarked no later than December 31st of the same Plan year (July 1 – June 30) in which the expense was incurred. For Members of Doctors Council Benefit Plan: All claims for benefits must be postmarked no later than June 30st for expenses incurred in the previous Plan year (Jan 1 – Dec 31)

FAILURE TO FILE REQUIRED DOCUMENTATION AND/OR SIGN EACH CLAIM FORM WILL CAUSE DELAY IN THE PROCESSING OF YOUR CLAIM, AND MAY CAUSE A DENIAL OF YOUR CLAIM.

IMPORTANT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.

MEMBER SIGNATURE

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED.

REIMBURSEMENTS ARE PAYABLE TO MEMBERS ONLY

SIGNATURE OF MEMBER

DATE