

DOCTORS COUNCIL WELFARE FUND
DOCTORS COUNCIL RETIREE WELFARE FUND

50 Broadway, 11th Floor, Suite 1101, New York, New York 10004 (212) 532-5995 Fax (212) 481-4137

CURRENTLY EMPLOYED RETIRED SELF-PAY COBRA

PLEASE COMPLETE THIS FORM AND SUBMIT IT POSTMARKED WITHIN 180 DAYS FROM THE DATE OF SERVICE, ALONG WITH YOUR RECEIPT FOR SERVICE(S) RENDERED. WHERE APPLICABLE, YOU MUST ALSO SUBMIT STATEMENTS FROM OTHER INSURANCE CARRIERS.

RETURN TO:

Doctors Council Welfare Fund
 50 Broadway, 11th Floor, Suite 1101
 New York, New York 10004
 PHONE: 212 532-5995 • FAX 212 481-4137

MEMBER INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #
ADDRESS <i>Street</i>	<i>City</i>		<i>State</i>	<i>Zip code</i>
HOME PHONE	WORK PHONE	FAX #	EMAIL ADDRESS	WORK SITE

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	RELATIONSHIP TO MEMBER
IS PATIENT A FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS PATIENT COVERED BY ANOTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME AND ADDRESS OF OTHER INSURER:				
NAME AND ADDRESS OF OTHER INSURER:				
NAME AND ADDRESS OF OTHER INSURER:				

BENEFIT YOU ARE APPLYING FOR: (CHECK ONE BOX ONLY)

HEARING AID BENEFIT (*Licensed Audiologist or Practitioner*) PODIATRY BENEFIT
 PSYCHIATRIC BENEFIT PRIVATE DUTY NURSING – IN HOSPITAL

PROVIDER INFORMATION : PROVIDER MUST COMPLETE THIS SECTION

NAME	ADDRESS	TELEPHONE NUMBER
DATE(S) OF SERVICE	DIAGNOSIS/DSM IV:	TREATMENT: For the Hearing Benefit indicate which ear(s) are affected.
PROVIDER MUST COMPLETE THE FOLLOWING: PSYCHIATRIST <input type="checkbox"/> PSYCHOLOGIST <input type="checkbox"/> <input type="checkbox"/> LICENSED CLINICAL SOCIAL WORKER (LCSW) <input type="checkbox"/> LICENSED AUDIOLOGIST OR PRACTITIONER		
LENGTH OF EACH VISIT _____	CHARGE PER VISIT \$ _____	TYPE OF VISIT: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP
PROVIDER'S SIGNATURE	DATE	PROFESSIONAL DEGREE: LICENSE NUMBER

MEMBER'S SIGNATURE

DATE

Office use only: Payment \$ _____ Approved By _____ Check Signed By _____