MEDICAL EQUIPMENT BENEFIT CLAIM FORM

HEALTH AND WELFARE FUND

POLICE BENEVOLENT ASSOCIATION OF THE CITY OF NEW YORK
125 BROAD STREET, 11TH FLOOR
NEW YORK, NY 10004
PHONE:(212) 349-7560 FAX: (212) 437-9480

WWW.NYCPBA.ORG

(SEE INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING)

CLAIM NO.

1. MEMBER'S SOCIAL SECURITY NO.	2. MEMBER'S NAME (LAST) (FIRST) (INITIAL)

3. MEMBER'S ADDRESS	NO. AND STREET	CITY	STATE	ZIP CODE

4. PATIENT'S NAME	5. RELATIONSHIP TO MEMBER	6. PATIENT'S DATE OF BIRTH
	☐ SELF ☐ SPOUSE ☐ DAUGHTER ☐ SON	Month / Day / Year

7. TYPE OF MEDICAL COVERAGE
(CHECK ONE) ☐ G.H.I. - C.B.P. / BLUE CROSS ☐ H.I.P. - H.M.O. ☐ MED. PLAN ☐ G.H.I. - TYPE C / BLUE CROSS

8. IF PATIENT HAS OTHER HEALTH INSURANCE COVERAGE, PLEASE GIVE POLICY HOLDERS NAME AND SOCIAL SECURITY NUMBER	NAME OF INSURANCE CARRIER	NAME AND ADDRESS OF EMPLOYER OR UNION

9. DESCRIPTION OF ITEM (S)	10. NAME & ADDRESS OF SUPPLIER	11. NAME & ADDRESS OF PRESCRIBING DOCTOR	12. DATE OF PURCHASE	13. COST

14. IS THE ABOVE ITEM(S) REQUIRED DUE TO: A WORK RELATED INJURY ☐ YES ☐ NO
AUTOMOBILE ACCIDENT ☐ YES ☐ NO
OTHER (PLEASE EXPLAIN) _____

☐ LINE OF DUTY N.Y.P.D. ☐ OTHER EMPLOYER: NAME OF EMPLOYER _____

15. I CERTIFY THAT THIS CLAIM IS FOR MEDICAL EQUIPMENT CHARGES ONLY, AND I AM ATTACHING HEREWITH AN **ITEMIZED BILL**

_____ SIGNATURE OF MEMBER

_____ DATE

FOR OFFICE USE ONLY

ELIGIBILITY CHECKED ON ___/___/___ BY _____

H I C _____

☐ ACTIVE ☐ RETIRED
☐ ELIGIBLE ☐ NOT ELIGIBLE _____

TOTAL $_____

COVERED EXPENSES $_____

C.O.B. - OTHER CARRIER PAYMENTS $_____

PRIOR PAID THIS YEAR $_____

PRIOR LIFETIME PAID $_____

EQUIPMENT CODE	AMOUNT TO PAY	REJECTION CODE
	$	
	$	
	$	

CODED BY	DATE

REMARKS: _____

AUDIT

INSTRUCTIONS

1. THIS FORM IS FOR CLAIMING MEDICAL EQUIPMENT CHARGES FOR ELIGIBLE MEMBERS AND THEIR DEPENDENTS.

2. THIS CLAIM MUST BE SUBMITTED TO THE FUNDS OFFICE WITHIN ONE YEAR OF THE PURCHASE OR LEASE DATE.

3. ALL INFORMATION REQUESTS ON THE FRONT OF THIS FORM MUST BE FILLED IN AND SIGNED BY THE MEMBER.

4. AN ITEMIZED BILL MUST BE ATTACHED TO THIS FORM. THE FUND RESERVES THE RIGHT TO REQUEST A COPY OF THE MD'S ORDER

CLAIMS NOT SUBMITTED IN ACCORDANCE WITH THESE PROCEDURES WILL BE RETURNED UNPROCESSED.

5. ALL CLAIMS SUBMITTED ARE SUBJECT TO COORDINATION OF BENEFITS (C.O.B.)

6. PAYMENTS ARE BASED ON 80% OF THE ALLOWABLE FEE. MAXIMUM PAYMENT IS $1,000.00 PER YEAR AND $3,500.00 PER LIFETIME PER FAMILY.

7. CLAIM FORM AND ITEMIZED BILL SHOULD BE MAILED TO:

PBA FUNDS OFFICE
125 BROAD STREET, 11TH FLOOR
NEW YORK, NY 10004