



MEDICAL EQUIPMENT BENEFIT

FUNDS OFFICE
 PATROLMEN'S BENEVOLENT ASSOCIATION
 of the City of New York
 125 Broad Street, 11th Floor
 New York, New York 10004

| |
|-----------|
| CLAIM NO. |
|-----------|

(SEE INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING)

| | | | |
|---------------------------------|-------------------------|---------|-----------|
| 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 <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DAUGHTER <input type="checkbox"/> SON | 6. PATIENT'S DATE OF BIRTH 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 _____

HIC _____

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:

**FUNDS OFFICE
OF THE
PATROLMEN'S BENEVOLENT ASSOCIATION
125 BROAD STREET, 11TH FLOOR
NEW YORK, NEW YORK 10004**