



# 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  
 SELF  SPOUSE  DAUGHTER  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**