MAIL TO:

NEW ROCHELLE FUSE WELFARE FUND

MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM

Administrative Services Only, Inc.
PO Box 9005, Dept. 27-M
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238

EFFECTIVE DATE: : January 1, 2006
ELIGIBILITY: Member, spouse and eligible dependent children.
ANNUAL MAXIMUM: $200.00 per member.
COVERED EXPENSES INCLUDE: Medical, Hospital Deductibles and Co-Payments, Prescription Drug Deductibles or Co-Payments under your group medical/surgical and hospital insurance. Charges incurred for health services covered in a member's existing coverages that exceed the reimbursement received, (including services covered under New Rochelle FUSE Welfare Fund).

PATIENT(S) INFORMATION

PATIENT NAME	CHARGES INCURRED	REIMBURSEMENT FROM ALL OTHER PLANS	NET OUT-OF-POCKET EXPENSES
1			
2			
3			
4			
TOTAL			

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	MALE FEMALE		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO. |									DAYTIME TELEPHONE NUMBER: EVENING TELEPHONE NUMBER:		

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(s) AFTER YOU HAVE ACCUMULATED $200.00 IN OUT OF POCKET EXPENSES OR AT THE END OF THE CALENDER YEAR**
2. **Do not submit your claim until the end of the plan year UNLESS you have already met the full amount of the benefit.**
3. **All claims for benefits must be postmarked no later than March 31st of the following year.**

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 NOTICE

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