MAIL TO:

NEW ROCHELLE FUSE WELFARE FUND

MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM 2019

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

EFFECTIVE DATE: January 1, 2019
ELIGIBILITY: For Active Members, spouses and eligible dependent children covered under the Fund's Supplemental coverage plan **(This benefit is NOT available to retirees.)**
ANNUAL FAMILY MAXIMUM- JANUARY 1, 2019:-$500 per member/family

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:		

HEALTH COVERAGE ENROLLMENT STATEMENT

This benefit is only available to members covered under a group health benefit plan. This benefit is **not** available if you opted out of the group health benefit plan offered through your employer and are not covered under another group health benefit plan. If you are covered under a plan purchased on an individual basis, including an ACA Exchange plan, this benefit is not available to you.

☐ **I am enrolled in the group health benefit plan provided by my employer**

☐ **I am enrolled in a group benefit plan provided by my spouse's employer**

Employer Name:_____ **Insurance Carrier:**_____ **Group No:**_____

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

NEW ROCHELLE FUSE WELFARE FUND
MEDICAL EXPENSE REIMBURSEMENT PROGRAM

What is covered? Under this program, you will receive reimbursement for $500 of out-of-pocket expenses that you and/or your family incur due to your annual medical deductible or co-payments and/or HMO/PPO co-payments from Group Health Plans.

Is there an Annual Maximum? Yes, There is an annual reimbursement maximum of **up to $500 per member/family.**

How Do I File for Benefits?

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 $500 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.

IN ORDER TO QUALIFY FOR REIMBURSEMENT
THE OUT-OF-POCKET EXPENSE MUST MEET ALL OF THE FOLLOWING REQUIREMENTS

1. It must be incurred on or after **January 1, 2019**
2. It must be covered under a group health benefit plan. This benefit is **not** available if you opted out of the group health benefit plan offered through your employer and are not covered under another group health benefit plan. If you are covered under a plan purchased on an individual basis, including an ACA Exchange plan, this benefit is not available to you.
3. It must appear in the list of **EXPENSES THAT CAN QUALIFY FOR REIMBURSEMENT**.
4. It must be medically necessary.
5. It must be documented by a detailed billing statement from the provider including the name, address, telephone number and tax identification number of the provider and nature of the medical services rendered and/or an explanation of benefits voucher from all other plans.
6. It must be rendered by a licensed provider as mandated by state law.

PARTIAL LIST OF EXPENSES THAT CAN QUALIFY FOR REIMBURSEMENT

• ALCOHOL AN SUBSTANCE ABUSE TREATMENT	• OPTICAL EXAMS, EYE GLASSES, CONTACTS AND VISION CORRECTION SERVICES	• OPERATIONS
• AMBULANCE	• HEARING AIDS	• PYSCHIATRIC CARE
• ARTIFICIAL LIMB	• HOSPITAL SERVICES	• PSYCHOANALYSIS
• BIRTH CONTROL PILLS	• LABORATORY FEES	• PSYCHOLOGISTS
• CHIROPRACTORS	• MEDICAL SERVICES	• THERAPY
• CO-INSURANCE & DEDUCTIBLES	• MEDICINES	• TRANSPLANTS
• DENTAL TREATMENT	• NURSING SERVICES	• WHEEL CHAIR