

MAIL TO:

**NEW ROCHELLE FUSE WELFARE FUND**  
**MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM 2020**

**Administrative Services Only, Inc.**

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

**EFFECTIVE DATE:** January 1, 2020

**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, 2020:-\$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			
<b>TOTAL</b>			

**MEMBER INFORMATION**

MEMBER NAME	BIRTH DATE	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		
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 31<sup>st</sup>** 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, 2020**
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