
The Newsletter of the Kingston Trust Fund



THE TRUSTEE

October 2025
Vol XIX, No.182



Emergencies

Emergencies occur all the time. If you have a medical emergency get medical attention as soon as possible. If there are questions about medical coverage, the provider can reach out to the Trust via the numbers on the front of your card and get the answers. With medications that require prior authorization, it is sometime confusing who to call and how to get it, particularly on weekends.

If you are faced with a “prescription emergency” where you must start your medication immediately, there is help available. Members can call Four Corners Health at 866-443-9331. If they cannot resolve it, please reach out to the Trust Compliance office at 844-583-3863 or John Olsen at 833-599-6777 ext. 200. Both numbers are monitored throughout the weekend. If you get a recording to leave a message, please do so. You will get a call back.

Prescription or Pharmacy Questions or concerns

Do you have any questions or concerns regarding your prescription costs or copays, or whether you should be using mail order versus local pharmacy. Have you gone to pick up a prescription and been told you have a large copay? You can get help and answers quickly using rx@ktftrustfund.com. You will get a response within 24 hours.

CanaRx Update

If you are currently getting medications from CanaRx you may be getting a call regarding the availability and cost of the medications. Due to new tariffs and regulations, your prescription may need to be transferred back to a local pharmacy or ManifestRx. Canada is currently experiencing a postal strike which they expect will negatively impact the delivery of some medications. There is also a 15% increase in the cost of the medications.

KTF Compliance Office

The KTF Compliance office is our members' best advocate! If you have questions about a claim or a copayment, they can help! If you are confused about benefits, they are experts on what is covered in the plan and to what extent. If you are confused about a bill or charges you received, they will investigate it and explain it. The compliance office is there to help! You can call them at 844-583-3863 or email them at appeals@kfftrustfund.org. If you call and are asked to leave a message, please do so. They are available Monday- Thursday from 9:00 to 5:00. Fridays are in office workdays, but they check the messages, and you will receive a call back, generally within 24 hours except on holidays and weekends.

Member reimbursements

Several members have reached out with questions on how to complete the member reimbursement forms. You can find the forms and instructions on completing them on the web at www.kfftrustfund.com on the left side of the web page under CLAIM FORMS.

For medical and dental reimbursement use the medical form . (You will also find a copy and the instructions attached to this edition of the *Trustee*.) In order to get your reimbursement quickly and efficiently complete the form as instructed and mail it to MagnaCare/ KTF Plan, PO Box 8085, Garden City, NY 11530.

For Gym Membership reimbursements, there is a separate form which can also be found on the website. (A copy is attached to this Trustee.) To receive reimbursement, members must use the membership for the year, then submit for reimbursement. Complete the form and submit it along with your payment receipt. Gym reimbursement forms and receipts should be email to appeals@kfftrustfund.com Gym memberships are paid one year after the date on the receipt.

Subrogation

If you were injured in an accident where other insurance (homeowners, car, or workers' compensation) may be involved, you must notify the Trust immediately. The Trust will pay your medical bills once you have signed a subrogation agreement with us. The agreement stipulates that if you receive a settlement, you will pay the Trust back for any medical cost incurred due to that injury/ event. Failure to do so will result in loss of KTF medical coverage.

Other Insurance Coverage

If you have medical or dental insurance in addition to your Kingston Trust Fund coverage, you must notify the Trust. There are rules regarding primary and secondary coverage. It is the member's responsibility to notify the Trust of all other coverage available to them and their covered family members. Failure to do so may require repayment or loss of coverage.

In Memoriam

Joan Putman

1. Please review the following requirements to ensure claims are able to be processed correctly:

Policy Holder information:

- Insured's Name - Box #4
- Insured's Date of Birth (DOB) - Box #11A

Patient information:

- Patient's Name - Box #2
- Patient's DOB - Box #3
- Patient's Address - Box #5
- Policy I.D. Number - Box #1A

Provider Information:

- Provider's Name - Box #33
- Provider's Tax I.D. Number - Box #25**
- Provider's Address - Box #33
- Provider's Telephone Number - Box #33

Claim Information:

- DOS (Dates of Service) - Box #24A
- CPT/ Procedure Codes - Box #24D**
- Diagnosis Codes - Box #24E**
- Billed amounts for each procedure - Box #24F

Each Date of Service should be completed on a separate line of the form
For example, for 3 different service dates, you would have 3 lines with a Date of Service, CPT /Procedure Code and the charge amount).

**This information may not be available for vision claims. Please supply if available.

2. Include all itemized bills, receipts and/or statements from the provider with each submission
3. Submit a separate claim form for each patient and/or provider
4. Print and submit completed form, itemized bill and/or receipt to:

MagnaCare
PO Box 8085
Garden City, NY 11530

PLEASE
DO NOT
STAPLE
IN THIS
AREA



APPROVED OMB-0938-0008

MagnaCare
PO Box 8085
Garden City, NY 11530

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																																																																																																																																																																																																																																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																																																																			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)																																																																																																																																																																																																																																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																																																																																																																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																																																																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																																																																																																																																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																																																																																																																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>If yes, return to and complete item 9 a-d.</i>																																																																																																																																																																																																																																			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																																																																																																																																																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																																																																																																																																																																													
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. I.D. NUMBER OF REFERRING PHYSICIAN										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																																																																																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)										23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																																																																													
1. _____ 3. _____ 2. _____ 4. _____										<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th colspan="2">DATE(S) OF SERVICE From</th> <th colspan="2">To</th> <th colspan="2">Place of Service</th> <th colspan="2">Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="2">DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th colspan="2">DAYS OR Family Plan</th> <th colspan="2">EMG</th> <th colspan="2">COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> <tr> <th>MM</th><th>DD</th><th>YY</th><th>MM</th><th>DD</th><th>YY</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>										A		B		C		D		E		F		G		H		I		J		K		DATE(S) OF SERVICE From		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR Family Plan		EMG		COB		RESERVED FOR LOCAL USE		MM	DD	YY	MM	DD	YY																																																																																																																																																																																		
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MM	DD	YY	MM	DD	YY																																																																																																																																																																																																																																																		
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. BALANCE DUE \$																																																																																																																																																																																																					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____																																																																																																																																																																																																																																			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500



Kingston Trust Fund
844-KTF-FUND

CLAIM FORM FOR REIMBURSEMENT OF HEALTH CLUB DUES

Name of Plan: **KINGSTON TRUST FUND**

Member Name: _____ Member ID#: _____

I certify that (select one) I; my family; my spouse and I had a health club membership the period of _____ to _____ and that I/we have actively participated at the health club for the past 12 month period. Verification of my/our membership in the _____ Club along with proof of payment for the annual dues of \$ _____ is attached.

I/We understand that the purpose of the Wellness benefit under the plan is to encourage members to pursue a more active lifestyle and to get regular exercise and I/we have, in good faith, used our membership in the above health/fitness club accordingly for the past year.

Member's Signature: _____ Date: _____

Attachments Required: Showing Proof of Annual Membership and Proof of Dues Paid

Email Claim to: appeals@ktftrustfund.com

OR

Mail Claim to: KINGSTON TRUST FUND
416 CREEKSTONE RIDGE
NEW YORK, NY 10038