HASTINGS TEACHERS' ASSOCIATION BENEFIT FUND

Statement of Claim for: Co-Pay Reimbursement

Claim Year: September 1 to August 31

MAIL TO:
Administrative Services Only, Inc.
PO Box 9005, Dept. 29-M
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238
Or
UPLOAD *ALL* paperwork to ASONET.com

PLEASE SEE INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM FOR HOW TO FILE A CLAIM.

CLAIM YEAR: SEPTEMBER 1 to AUGUST 31

CLAIM YEAR MAXIMUM BENEFIT: YOU WILL BE REIMBURSED 50% OF THE FIRST $600 OF YOUR CO-PAY COSTS. THE MAXIMUM PLAN PAYMENT WILL BE $300 PER FAMILY OR INDIVIDUAL.

FILING DEADLINE: ALL CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS FROM THE DATE OF NOTICE ON THE EXPLANATION OF BENEFITS.

MEMBER INFORMATION

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

PLEASE LIST THE EXPENSES INCURRED AND ATTACH THE ORIGINAL EXPLANATION OF BENEFITS VOUCHER FROM THE MEDICAL PLAN PROVIDED BY THE DISTRICT ALONG WITH PROOF OF PAYMENT TO THE PROVIDER.

DATE OF SERVICE	PATIENT NAME	BIRTH DATE	RELATIONSHIP TO MEMBER (SELF, SPOUSE, CHILD, DOMESTIC PARTNER)	AMOUNT CLAIMED
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
			TOTAL AMOUNT CLAIMED	$

MEMBER SIGNATURE-REIMBURSEMENTS ARE PAYABLE TO THE MEMBER ONLY.

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 WERE THE AMOUNT BILLED.

SIGNATURE OF MEMBER _____ **DATE** _____

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CLAIM YEAR: SEPTEMBER 1 TO AUGUST 31

CLAIM YEAR BENEFIT: YOU WILL BE REIMBURESED 50% OF THE FIRST $600 OF YOUR CO-PAY COSTS. THE MAXIMUM BENEFIT PLAN PAYMENT WILL BE $300 PER PERSON OR FAMILY.

FILING DEADLINE: ALL CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS FROM THE DATE OF NOTICE ON THE EXPLANATION OF BENEFITS.

HOW TO FILE A CLAIM:

- LIST THE EXPENSE BEING CLAIMED ON THE FRONT SIDE OF THIS FORM. INCLUDE ALL OF THE PATIENT INFORMATION.
- ATTACH THE EXPLANATION OF BENEFITS TO THE CLAIM FORM.
- INCLUDE PROOF OF PAYMENT IN THE FORM OF A CANCELED CHECK, CREDIT CARD STATEMENT OR A PAID RECEIPT FROM THE PROVIDER.
- 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.