# HASTINGS TEACHERS' ASSOCIATION BENEFIT FUND

**Statement of Claim for:** Medical Expense Reimbursement
**Claim Year:** January 1 to December 31

**MAIL TO:**
**Administrative Services Only, Inc.**
PO Box 9005, Dept. 29-M
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238

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

**CLAIM YEAR:** JANUARY 1 to DECEMBER 31

**CLAIM YEAR MAXIMUM BENEFIT:** $350 PER PERSON OR $700 PER FAMILY, WHERE NO INDIVIDUAL MAY CLAIM MORE THAN $350.

**FILING DEADLINE:** ALL CLAIMS MUST BE SUBMITTED WITHIN 120 FROM THE DATE OF SERVICE RECORDED 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:<br>EVENING TELEPHONE NUMBER: | | |

## PATIENT INFORMATION (REQUIRED ON ALL CLAIMS)

| Patient's Name | **Birth Date** | Relationship to Member |
|---|---|---|
| | ____/___/____ | ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child |

**PLEASE LIST THE EXPENSES INCURRED AND ATTACH THE ORIGINAL EXPLANATION OF BENEFITS VOUCHER FROM THE MEDICAL PLAN PROVIDED BY THE DISTRICT.**

| DATE(S) OF SERVICE | TYPE OF EXPENSE | AMOUNT CLAIMED |
|---|---|---|
| | ☐ **DEDUCTIBLE** ☐ **CHARGES NOT COVERED** | |
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| | ☐ **DEDUCTIBLE** ☐ **CHARGES NOT COVERED** | |
| | ☐ **DEDUCTIBLE** ☐ **CHARGES NOT COVERED** | |
| | **TOTAL AMOUNT CLAIMED** | |

**QUALIFIED EXPENSES:**

- **DEDUCTIBLE -** CAN ONLY BE CLAIMED FOR PAYMENT TOWARD THE MAJOR MEDICAL DEDUCTIBLE REQUIREMENT CHARGED BY NON-PARTICIPATING PROVIDERS**.**
- **CHARGES NOT COVERED** - SEE "CHARGES NOT COVERED" WITHIN THE "YOUR RESPONSIBILITY" BOX ON THE EXPLANATION OF BENEFITS FROM BOTH PARTICIPATING AND NONPARTICIPATING PROVIDERS WITHIN THE HEALTH INSURANCE PLAN PROVIDED BY THE DISTRICT.

## 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 MAXIMUM BENEFIT**: $350 PER PERSON OR $700 PER FAMILY, WHERE NO INDIVIDUAL MAY CLAIM MORE THAN $350**.**

**FILING DEADLINE:** ALL CLAIMS MUST BE SUBMITTED WITHIN 120 DAYS FROM THE DATE OF SERVICE RECORDED ON THE EXPLANATION OF BENEFITS.

**QUALIFIED EXPENSES:**

- **DEDUCTIBLE -** CAN ONLY BE CLAIMED FOR PAYMENT TOWARD THE MAJOR MEDICAL DEDUCTIBLE REQUIREMENT CHARGED BY NON-PARTICIPATING PROVIDERS**.**
- **NOT COVERED** - SEE " NOT COVERED" COLUMN ON THE EXPLANATION OF BENEFITS FROM BOTH PARTICIPATING AND NONPARTICIPATING PROVIDERS WITHIN THE HEALTH INSURANCE PLAN PROVIDED BY THE DISTRICT.

**PLEASE NOTE THAT CO-PAYMENTS ARE NOT COVERED UNDER THIS PLAN-these charges Include, but are not limited to, "office visits" in $20 increments OR "laboratory services" co-payments, both of which are listed in the co-pay/deductible column.**

**HOW TO FILE A CLAIM:**

- LIST THE EXPENSE BEING CLAIMED ON THE FRONT SIDE OF THIS FORM.
- ATTACH THE EXPLANATION OF BENEFITS TO THE CLAIM FORM.
- SUBMIT YOUR CLAIM ONCE YOU HAVE RECEIVED YOUR EXPLANATION OF BENEFITS TO ENSURE YOU GET THE FULL BENEFIT.
- INCLUDE PROOF OF PAYMENT IN THE FORM OF A CANCELLED 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.