

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

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: 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 DAYS FROM THE DATE OF NOTICE ON
THE EXPLANATION OF BENEFITS.****MEMBER INFORMATION**

MEMBER NAME	BIRTH DATE	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
ADDRESS	APT. NO.	CITY	STATE ZIP CODE
SOCIAL SECURITY NO. <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> - <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> - <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	DAYTIME TELEPHONE NUMBER: EVENING TELEPHONE NUMBER:		

PATIENT INFORMATION (REQUIRED ON ALL CLAIMS)

Patient's Name	Birth Date ____/____/____	Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child
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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(S) OF SERVICE	TYPE OF EXPENSE	AMOUNT CLAIMED
	<input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> NOT COVERED	
	<input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> NOT COVERED	
	<input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> NOT COVERED	
	<input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> 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.
- **NOT COVERED** - SEE "NOT COVERED" 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 _____

HASTINGS TEACHERS' ASSOCIATION BENEFIT FUND

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- **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 ALL CO-PAYMENTS ARE NOT COVERED UNDER THIS PLAN – these charges include, but are not limited to, "office visits" in \$25 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 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.