

Mail
Claims
To:

Administrative Services Only
P.O. Box 9005, Dept. 22M
Lynbrook, NY 11563-9005
Telephone: (516) 396-5500
Toll Free: (877) 390-5845



Organization of Staff Analysts Welfare Fund

CLAIM FOR SUPERIMPOSED MAJOR MEDICAL BENEFITS

IT IS A CRIME TO FILL OUT THIS FORM WITH INFORMATION YOU KNOW IS FALSE, OR TO LEAVE OUT FACTS YOU KNOW ARE IMPORTANT.

See Reverse For Instructions On Filing Our and Sending In This Claim Form
Sections A & D Must Be Completed by The Employee
Sections B & D Must Be Completed by The Patient
Section C Must Be Completed if Claim is Due to an Accident or Occupational Illness/Injury

A. EMPLOYEE INFORMATION

SOCIAL SECURITY # <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> - <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		DATE OF BIRTH / /		IF RETIRED OR DISABLED PLEASE ENTER THE DATE IN THE SPACES PROVIDED	
<input type="checkbox"/> ACTIVE		<input type="checkbox"/> MEDICARE ELIGIBLE		<input type="checkbox"/> RETIRED DATE / /	
<input type="checkbox"/> DISABLED DATE / /		LAST NAME		FIRST NAME	
MI		ADDRESS		WORK TELEPHONE # () -	
CITY		STATE		ZIP	
HOME TELEPHONE # () -		CITY HEALTH PLAN NAME:		TYPE OF PLAN: (FOR EXAMPLE: QPOS, HMO, PPO, ETC.)	
PRESCRIPTION DRUG COVERAGE: <input type="checkbox"/> YES <input type="checkbox"/> NO		PLEASE ATTACH COPY OF ALL HEALTH PLAN IDENTIFICATION CARDS			
IS THERE ANY OTHER COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		YOU MUST LIST ALL OTHER COVERAGES, INCLUDING MEDICARE COVERAGE			
	INSURED ID#	PLAN NAME AND PLAN NUMBER	PLAN EMPLOYER OR SPONSOR		
MEMBER					
SPOUSE/DOMESTIC PARTNER					
SPOUSE/DOMESTIC PARTNER (ADDITIONAL COVERAGE)					
DEPENDENT					

B. PATIENT INFORMATION (Complete only if patient is other than employee)

LAST NAME		FIRST NAME		MI	
SOCIAL SECURITY #: <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> - <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		DATE OF BIRTH: (month/day/year) ___/___/___			
RELATIONSHIP TO EMPLOYEE: <input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER: (please specify) _____					
IS PATIENT AN UNMARRIED DEPENDENT CHILD AGE 19 OR OLDER? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, dependent child is: <input type="checkbox"/> Employed F/T <input type="checkbox"/> Student F/T <input type="checkbox"/> Disabled			

C. ACCIDENT/OCCUPATIONAL CLAIM INFORMATION (Complete only if claim is a result of an accident or occupational illness/injury)

Is claim due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Accident: (month/day/year) ___/___/___			
Is illness/injury: <input type="checkbox"/> Employment-related <input type="checkbox"/> Auto-related <input type="checkbox"/> Other: (please specify) _____					
Describe accident or occupational illness/injury: _____					

D. MEMBER/PATIENT'S SIGNATURE AND RELEASE (Member must sign all claims. If not a minor, dependent patient must also sign.)

I hereby apply for benefits and certify that the above information is complete, true and correct.

To all physicians and other medical professionals, hospitals and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit plan administrators: you are authorized to provide Administrative Services Only, Inc. and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on Administrative Services Only, Inc.'s behalf, with information concerning medical care, advice, treatment or supplies provided to the Patient, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

Claim cannot be processed without member's signature.

Member's Signature _____

Date _____

Patient's Signature, if other than member, and if patient is not a minor _____ Date _____

WHAT IS THE SUPERIMPOSED MAJOR MEDICAL PROGRAM (SMMP)?

The Superimposed Major Medical Program (**SMMP**) provides supplemental insurance for those members who have qualifying out-of-pocket expenses, which remain after their primary health coverage allowance has been applied. Please refer to the **Organization of Staff Analysts Welfare Fund Benefits Booklet** for a complete list of covered expenses, including exclusions, limitations and maximums.

Examples of Qualified Covered Services Include:

- √ Medical Office Visits
- √ Prescription Medications
- √ Hospital Stays
- √ Deductibles & Co-Payments
- √ Hearing Aids
- √ Surgery
- √ Out-Patient Mental Health Care

WHEN SHOULD A CLAIM BE FILED?

- Once you have accumulated out-of-pocket expenses equal to or in excess of your SMMP deductible, you should submit a claim.
- The SMMP has three different deductible* levels (per calendar year).
- Once the deductible is satisfied, the SMMP reimburses 90% of reasonable and customary non-reimbursed covered medical expenses, and 80% of prescription medications, subject to benefit maximums.

*If Primary Health Benefits Cover:

Calendar Year Deductible

(This is the deductible per covered individual.)

With a Prescription Drug Rider	\$ 500
Without a Prescription Drug Rider	\$ 2,000
Without Basic Health Plan	\$ 10,000

HOW SHOULD CLAIMS BE SUBMITTED?

1. Submit medical bill to your primary health plan for payment (or to apply charges toward a deductible or co-insurance).
Please note: If you are a participant in the Health Benefits Buy-Out Waiver Program, you are covered for primary health benefits either under your spouse's plan or through other employment. In these cases, medical expenses must still be submitted to those other plans for payment.
2. If you are covered under both the City's Health Benefits Program and a spouse's plan (or a plan through other employment), medical bills must be submitted to BOTH plans before the SMMP.
3. Compile all itemized bills generated from your service provider related to claims.
4. Compile the Explanation of Benefits vouchers (EOB) provided by your primary health plan(s) in reference to the above itemized bills.
5. Once you have accumulated out-of-pocket covered medical expenses equal to or in excess of you SMMP deductible, prepare the above documentation for submission to the SMMP.
6. Complete the SMMP claim form and submit with all documentation (i.e. itemized bills, EOBs) for processing to:

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