General Building Laborers' Local 66 Welfare Fund

Supplemental Medicare Reimbursement Claim Form

MAIL TO:
Administrative Services Only, Inc.
PO Box 9005, Dept. 67-M
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238
web @ www.asonet.com

Covered Expenses include: Medical and Hospital Deductibles and Co-Payments under Medicare. This plan only considers remaining balances for services covered and reimbursable under Medicare.

There is no deductible for service dates on or after 7/1/2004.

MEMBER / PATIENT INFORMATION

NAME	BIRTH DATE	MALE ☐ FEMALE ☐	U.S. SOCIAL SECURITY NO.		
ADDRESS	APT. NO.	CITY		STATE	ZIP CODE
DAYTIME TELEPHONE NUMBER		EVENING TELEPHONE NUMBER			
NAME ALL BENEFIT PLANS COVERING THIS PATIENT					

IS THIS PATIENT COVERED BY A:
(1) MEDICAL PLAN ☐ YES ☐ NO (2) DENTAL PLAN ☐ YES ☐ NO (3) VISION PLAN ☐ YES ☐ NO

SERVICE RELATED TO :
(1) EMPLOYMENT ☐ CURRENT ☐ PREVIOUS (2) AUTO ACCIDENT ☐ YES ☐ NO (3) OTHER ACCIDENT ☐ YES ☐ NO

HOW TO FILE A CLAIM

1. **Complete the claim form and attach all copies of the itemized bills for the expenses incurred and the corresponding explanation of benefits vouchers FROM ALL HEALTH INSURANCE PLANS covering the patient.**
2. **File a separate claim form for each family individual covered under Medicare and this plan.**
3. **All claims for benefits must be postmarked no later than 365 days from the date service is rendered.**

IMPORTANT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.

MEMBER SIGNATURE

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 WAS THE AMOUNT BILLED.

SIGNATURE OF MEMBER / SPOUSE — DATE

ASSIGNMENT OF BENEFITS: *I hereby authorize payment of the benefits (otherwise payable to me) directly to the provider of service.*

SIGNATURE OF MEMBER / SPOUSE — DATE