PSC-CUNY Welfare Fund Extended Medical Benefit Claim Form

Administrative Services Only, Inc
Department # 178
P.O. Box 9009
Lynbrook, NY 11563-9009
1-877-362-2869

Member Information

Member Name *(First, MI, Last)* _____

Member Status ---------- Active Employee ☐ non-Medicare ☐ GHI Category # (found on GHI Card)

Retiree ☐ Medicare ☐ 262___ 271___ 299___

Member Social Security Number _____

Member Date of Birth _____ Phone # _____

Member Address _____ Apt. No. ___

_____ City _____ State _____ Zip

Patient Information

Patient Name *(First, MI, Last)* _____ Relationship _____

Patient Date of Birth _____

Other Insurance

Please indicate **other** health insurance available for this patient

Member ☐		Name of Employer	Insurance Carrier	Contract #
Spouse ☐	Spouse Name & SSN	Name of Employer	Insurance Carrier	Contract #
Patient ☐	Patient Name &SSN	Name of Employer	Insurance Carrier	Contract #

Services

Please attach your GHI Explanation of Benefits and your Itemized Bill, which includes descriptions and procedure codes.

GHI Claims #		Date(s) of Service		Total Charges			Total Payment	

With this Application for Benefits under the PSC-CUNY Welfare Fund I hereby certify that I am eligible for benefits and that all statements are true and accurate.
I authorize the release of any necessary medical, employment or insurance information by service providers, insurors, employers, attorneys or benefit administrators to Administrative Services Only, Inc for the purpose of evaluating and adjudicating this claim.
I understand that I have a right to receive a copy of this authorization on request. I agree that a true image of this authorization is as valid as the original.

_____ Signature _____ Date