



# HOUSE STAFF BENEFITS PLAN

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## OUT-PATIENT PSYCHIATRIC FORM

Eligibility: HSBP employees including eligible dependents.

Maximum reimbursement allowed: 80% of all reasonable and customary charges incurred by patient up to \$5,000. However, in no case will the maximum benefit per individual per Benefit Year exceed \$5,000.

Claim Submission Rules:

- Entire claim form must be completed in full by participant or patient and eligible provider with the exact date(s), diagnosis and procedure codes for which services were rendered. Eligible providers must be certified and licensed. Their degrees can be any one of the following: M.D., PhD., EdD., PsyD. (Doctor of Psychology). MSW (Master of Social Work) or CSW (Certified Social Worker).
- A separate claim form must be submitted per patient.
- All claims must be submitted to our office at the above-mentioned address within one year of the date of service. Claims submitted after one year will be denied.

### SECTION A: TO BE COMPLETED BY PARTICIPANT:

Participant's Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
(Last Name) (First Name)

Hospital where employed: \_\_\_\_\_ Single Married Divorced Separated

Home Address: \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip code)

Contact phone number: \_\_\_\_\_ Type (home, mobile, etc.) \_\_\_\_\_

E-mail address: \_\_\_\_\_

In order for this claim to be processed, the authorization below must be completed.

I hereby certify that the above statements are correct

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SECTION B: TO BE COMPLETED BY PATIENT:

Patient's Name: \_\_\_\_\_  
(Last Name) (First Name)

Date of Birth: \_\_\_\_\_ Relations to participant: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(City) (State) (Zip code)

Within the last 12 months, have you been on the payroll of another Hospital? Yes No

If yes, name of Hospital: \_\_\_\_\_

At the time charges were incurred, was your spouse employed? Yes No

If yes, name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Other than medical coverage provided to the HSO by his or her employer and the House Staff Benefits Plan, is the patient also covered for benefits by any other Group Health Plan. Yes No

If yes, please provide:



I hereby certify that the above statements are correct

Signature of Physician or Provider or Service: \_\_\_\_\_ Date: \_\_\_\_\_

(3/1/10)