HOUSE STAFF BENEFITS PLAN

520 EIGHTH AVENUE, SUITE 1200 NEW YORK, NY 10018-4181

Phone: (212)-356-8180 **Fax: (212)-356 – 8181** **benefits@cirseiu.org** **www.cirseiu.org**

SUPPLEMENTAL MAJOR MEDICAL BENEFIT CLAIM FORM

Eligibility**:** HSBP employees including eligible dependents.

Maximum reimbursement allowed: The maximum supplement per person per benefit year is $1,000. This supplement will pay an additional 20% of the amount reimbursed in connection with benefits provided by your primary major medical carrier. This 20% supplement will be calculated based on the total reimbursements received under your primary plan during the benefit year. Co-payments are covered at 100%. **Deductibles are not covered.** In addition Smoking Cessation is covered up to $125 for group sessions or hypnosis for participants who cease smoking. Acceptable programs include Smoke Enders, and programs sponsored by the New York Lung Association. The Smoking Cessation Benefit can also be used to reimburse you for nicotine patches or gum. In no way will the reimbursement be more than what was paid

Claim Submission Rules:

- Entire claim form must be completed in full by participant, patient or parent, if minor.
- A separate claim form must be submitted per patient.
- You must attach the Explanation of Benefits (EOB) received from your primary carrier. Co-payment receipts from your provider's office are not acceptable as proof of service.
- All claims must be submitted to our office via fax or mail (contact info in letterhead) within one year from the date of service. *Do not email claims.*
- Claims submitted after one year will be denied.

Please complete the following:

Participant's Name: ____________________________ ________________________________
(Last Name) (First Name)

Social Security No.: ___________________ Hospital where employed: ___________________

Home Address: ___________________________ _________________________ ______
(No. and Street) (City and State) (Zip code)

Contact phone number: ____________________ Type (home, mobile, etc.) ________________

E-mail address: ___________________________

Patient's Name: _____________________________ _________________________________
(Last Name) (First Name)

Relationship to participant: ________________

Number of Explanations of Benefits (EOB's) attached: _______________

Patient's Signature or parent, if minor: _________________________ Date: ________________