HOUSE STAFF BENEFITS PLAN

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

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NEWBORN BENEFIT CLAIM FORM

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

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 submit bill from provider or an Explanation of Benefits (EOB) from your primary insurance carrier along with this claim form.
- Claims must be submitted via fax or mail (contact info in letterhead) within one year of date of service. *Do not email claims*. Claims submitted after one year will be denied.

Covered Services: The Plan reimburses up to a maximum of $1,000 for:

- **Newborn Expenses** - any unreimbursed ***medical expenses*** in connection with a newborn for the first 60 days of the child's life (including children who are adopted);
- **Well Baby Care** - pediatrician's in-hospital newborn baby care;
- **Circumcision** - by a physician or a certified mohel up to 24 months old;
- **Childbirth Education -** information and education about childbirth by providing up to 6 group sessions or 3-4 private sessions conducted by licensed practitioners.

You may divide the $1,000 sum among one to four benefits or use the entire sum for one of the benefits. In no instance will the maximum benefit per individual exceed $1,000.

Note: You must add your newborn to the benefits plan by completing an HSBP Enrollment Form (available on website under Benefit Forms) before receiving reimbursement for newborn expenses. Adding your child to your hospital's medical plan does NOT mean your child is enrolled in HSBP - you must complete a separate HSBP enrollment form.

Please complete the following:

Participant's Name: ______________________________ ______________________________
(Last Name) (First Name)

Social Security No.: ____________________ Hospital where employed: ___________________

Home Address: ____

_________________________________ ________ ___________________
(City) (State) (Zip code)

Contact phone number: _____________________Type (home, mobile, etc.) _________________

E-mail address: _____________________________________

Name of baby: ____________________ _____________________ Date of Birth: ____/____/______
(Last Name) (First Name)

Patient's Signature: ___________________________________ Date: _________________

(05/13)