Committee of Interns and Residents
SEIUHealthcare

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**

URINANALYSIS MONITORING REIMBURSEMENT

Eligibility: HSBP employees including eligible dependents.

Guidelines: Benefits are provided when certain services are required by the Committee of Physicians Health of the Medical Society of the State of New York. Two types of care are covered:

- In case of substance abuse suspicion: expenses incurred from urinalysis monitoring will be reimbursed at 100% of expenses up to a maximum of $400 per month for a maximum period of 24 months.
- In case of substance abuse: AFTERCARE will be reimbursed at 80% of expenses up to a maximum of $400 per month for a maximum period of 24 months.

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.
- 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.

SECTION A: TO BE COMPLETED BY PARTICIPANT:

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

Social Security No.: _____ Hospital where employed: _____

Home Address: _____ _____ _____ _____
(No. and Street) (City) (State) (Zip code)

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

E-mail address: _____

SECTION B: TO BE COMPLETED BY PATIENT:

Patient's Name: _____ _____
(Last Name) (First Name)

Date of Birth: _____ Relationship to participant: _____

Home Address: _____ _____ _____ _____
(No. and Street) (City) (State) (Zip code)

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:

Name of employer, organization or educational institution which provides coverage: _____

Address: _____

Name of Insurance Company: _____ Group Policy Number: _____

In order for this claim to be processed, the authorization below must be completed:
I authorize the release of any information necessary to process this claim (including information from physicians, providers of service, clinics, and all other agencies or insurance companies). This information, when required, may only be released to the House Staff Benefits Plan or its representatives.

Patient's Signature: _____ Date: _____

SECTION C: TO BE COMPLETED ONLY BY THE ATTENDING PROVIDER OF SERVICE:

Name of Physician: _____ _____ Tax ID No.: _____
(Last Name) (First Name)

Degree: _____ License No.: _____ Phone number: _____

Address: _____ _____ _____ _____
(No. and Street) (City) (State) (Zip code)

Diagnosis: _____

Diagnosis Code: _____ Date Patient first consulted you for this condition: _____

Complete Below or Attach Itemized Bills:

	Date of Service	Charges
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

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

I hereby certify that the above statements are correct

Signature of Physician or Provider: _____ Date: _____

(05/13)