



GROUP CATASTROPHE MAJOR MEDICAL PLAN

Sponsored by NYSUT Member Benefits Catastrophe Major Medical (CMM) Insurance Trust

PLEASE NOTE

USE THIS CLAIM FORM FOR BENEFIT PERIOD START DATES PRIOR TO JANUARY 1, 2018

- CMM Plan Certificate of Insurance (Policy # E-610,219) applies for benefit period effective dates before January 1, 2014.
- CMM Plan Document (Policy # CMMI-002) applies for benefit period effective dates between January 1, 2014 and December 31, 2017.
- **DO NOT USE THIS FORM** for benefit period effective dates on or after January 1, 2018 regarding CMM Policy # CMMI-004; rather send your claim to HealthSmart (healthsmart.com/nysut or 844-552-7805).

CLAIM FORM INSTRUCTIONS

- 1) Fully complete the Insured/Claimant's Information section and sign in the space provided.
- 2) Read the Fraud Statement section and sign in the space provided.
- 3) Review and sign the HIPAA Authorization Form. The authorization will assist Association Member Benefits Advisors (AMBA), the Plan Administrator, to obtain any additional information needed to complete the processing of your claim. Failure to provide the authorization may delay the processing of your claim.
- 4) Include the following supporting documents (if applicable):
 - Corresponding statements of payment or denial from **all** other insurance carriers, commonly known as an Explanation of Benefits (EOB);
 - Itemized invoices from your health care providers. This will provide the claim processor with information important to your claim.
- 5) Mail your claims to:

Association Member Benefits Advisors
PO Box 10362
Des Moines, IA 50306
Questions: 888-386-9788

Important: Claims must be filed within five (5) years of incurring the claim expense.

INSURED/CLAIMANT INFORMATION SECTION

Name of Insured (first, middle initial, last) (Please Print)		NYSUT ID # (seven-digit)		Policy Number CMMI-002 E-610,219	
Insured's Address, Street & No.			City		State Zip
Single <input type="checkbox"/>	Divorced <input type="checkbox"/>	Other <input type="checkbox"/>	Date of Birth	Home Phone	Daytime Phone
Married <input type="checkbox"/>		Widowed <input type="checkbox"/>			
Patient's Name for whom claim is being made (first, middle initial, last)				Patient's Relationship to Insured	
Patient's Address, Street & No.			City		State Zip
Patient's Date of Birth		Single <input type="checkbox"/>	Is Patient Employed?		
		Married <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is the patient eligible for coverage under an employer-sponsored health plan?			Yes <input type="checkbox"/> No <input type="checkbox"/>		



Nature of Patient's Sickness or Injury			
If related to an injury, how, when and where did the injury occur?			
If hospitalized, give name and address of hospital			Dates of confinement
Attending Physician's Name			
Attending Physician's Address, Street & No.		City	State Zip
Attending Physician's Telephone Number			
Please indicate by checking yes or no and providing the policy number if you and/or the patient have coverage under any of the following plans.			
Medicaid -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Policy # _____	Effective Date: _____
Medicare -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Policy # _____	Effective Date: _____
United -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Policy # _____	Effective Date: _____
BlueCross -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Policy # _____	Effective Date: _____
CSA -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Policy # _____	Effective Date: _____
GHI -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Policy # _____	Effective Date: _____
S.H.I.P. -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Policy # _____	Effective Date: _____
AARP -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Policy # _____	Effective Date: _____
RSSA -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Policy # _____	Effective Date: _____
Please list all other coverages you and/or the patient may have. If space is not adequate, use separate page.			
Insurance Co. Name & Address: _____			
Policy # _____		Effective Date: _____	
Insurance Co. Name & Address: _____			
Policy # _____		Effective Date: _____	
Insurance Co. Name & Address: _____			
Policy # _____		Effective Date: _____	
<p>IMPORTANT NOTICE: It is unlawful for any person to knowingly, and with the intent to defraud, present, or cause to be presented, or prepare with the knowledge and belief that it will be presented to a self-insurer, a claim for payment, containing any materially false information concerning any material fact related to such claim, or to conceal, for the purpose of misleading, information concerning any material fact related to such claim (collectively, "Unlawful Acts"). Such Unlawful Acts may also lead to a denial of benefits from this Plan.</p>			
_____ Signature of Insured		_____ Date	



**Health Insurance Portability and Accountability Act (“HIPAA”)
Authorization to Obtain and Disclose Information**

Patient’s Name	Date of Birth	NYSUT Member ID # (seven-digit)
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I hereby authorize all of the people and organizations listed below to give NYSUT Member Benefits Catastrophe Major Medical Insurance Trust (“Trust”), and their authorized representatives, including its administrator, Association Member Benefits Advisors (AMBA), as well as other agents and insurance support organizations, (collectively, the "Recipients"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company;
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipients to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Recipients listed above are subject to federal privacy regulations. I understand that information released to the Recipients will be used and disclosed as described in the Trust’s HIPAA Privacy Notice, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipients to contest a claim under the policy or to contest the policy itself, by sending a written request to: Association Member Benefits Advisors, PO Box 10362, Des Moines, IA 50306-0362. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipients for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Recipients may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signature of Claimant or Claimant’s Personal Representative

Date

Description of Authority of Personal Representative (if applicable)