MEMBER BENEFITS
nysut
Working to Benefit You

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-170,129) applies for benefit period effective dates before January 1, 2014.
- CMM Plan Document (Policy # CMMI-001) 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-003; 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-001 E-170,129**	
Insured's Address, Street & No.		City	State	Zip
Single ☐ Divorced ☐ Other ☐ Married ☐ Widowed ☐	Date of Birth	Home Phone	Daytime Phone	
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 ☐ Married ☐	Is Patient Employed? Yes ☐ No ☐		
Is the patient eligible for coverage under an employer-sponsored health plan? Yes ☐ No ☐				

MEMBER BENEFITS
nysut
Working to Benefit You

INSURED/CLAIMANT INFORMATION SECTION
Continued

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 ☐ No ☐ Policy #_____ Effective Date: _____

Medicare - Yes ☐ No ☐ Policy #_____ Effective Date: _____

United - Yes ☐ No ☐ Policy #_____ Effective Date: _____

BlueCross - Yes ☐ No ☐ Policy #_____ Effective Date: _____

CSA - Yes ☐ No ☐ Policy #_____ Effective Date: _____

GHI - Yes ☐ No ☐ Policy #_____ Effective Date: _____

S.H.I.P. - Yes ☐ No ☐ Policy #_____ Effective Date: _____

AARP - Yes ☐ No ☐ Policy #_____ Effective Date: _____

RSSA - Yes ☐ No ☐ 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: _____

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.

_____ _____

Signature of Insured Date

MEMBER BENEFITS
nysut
Working to Benefit You

HIPAA Authorization Section
Claims

Health Insurance Portability and Accountability Act ("HIPAA")
Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	NYSUT Member ID # (seven-digit)

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)