PSC-CUNY Welfare Fund   Extended Medical Benefit   Claim Form

Administrative Services Only, Inc
Department # 178
P.O. Box 9009
Lynbrook, NY 11563-9009
1-877-362-2869

Member Information

Member Name *(First, MI, Last)* ______________________________

Member Status ------------- Active Employee ☐ non-Medicare ☐ GHI Category # (found on GHI Card)

Retiree ☐ Medicare ☐ 262___ 271___ 299___

Member Social Security Number ______________________

Member Date of Birth ______________________ Phone # ______________________

Member Address ______________________________ Apt. No. __

______________________ City ______ State ______ Zip

Patient Information

Patient Name *(First, MI, Last)* ______________________ Relationship ____________

Patient Date of Birth ______________________

Other Insurance

Please indicate **other** health insurance available for this patient

Member ☐ ______________________ Name of Employer Insurance Carrier Contract #

Spouse ☐ Spouse Name & SSN Name of Employer Insurance Carrier Contract #

Patient ☐ Patient Name &SSN Name of Employer Insurance Carrier Contract #

Services

Please attach your GHI Explanation of Benefits and your Itemized Bill, which includes descriptions and procedure codes.

GHI Claims #		Date(s) of Service		Total Charges			Total Payment	

With this Application for Benefits under the PSC-CUNY Welfare Fund I hereby certify that I am eligible for benefits and that all statements are true and accurate.
I authorize the release of any necessary medical, employment or insurance information by service providers, insurors, employers, attorneys or benefit administrators to Administrative Services Only, Inc for the purpose of evaluating and adjudicating this claim.
I understand that I have a right to receive a copy of this authorization on request. I agree that a true image of this authorization is as valid as the original.

______________________________ Signature ____________ Date