MAIL TO:

NEW ROCHELLE FUSE WELFARE FUND

MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM

2025

Administrative Services Only, Inc.
PO Box 9005, Dept. 27-M
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238

EFFECTIVE DATE: **January 1, 2025**

ELIGIBILITY: For Active Members, spouses and eligible dependent children covered under the Fund's Supplemental coverage plan (This benefit is NOT available to retirees.)

ANNUAL FAMILY MAXIMUM **January 1, 2025** -$500 per member/family

COVERED EXPENSES INCLUDE: Medical, Hospital Deductibles and Co-Payments, Prescription Drug Deductibles or Co-Payments under your group medical/surgical and hospital insurance. Charges incurred for health services covered in a member's existing coverages that exceed the reimbursement received, (including services covered under New Rochelle FUSE Welfare Fund).

PATIENT(S) INFORMATION

PATIENT NAME	CHARGES INCURRED	REIMBURSEMENT FROM ALL OTHER PLANS	NET OUT-OF-POCKET EXPENSES
1			
2			
3			
4			
TOTAL			

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	MALE ☐ FEMALE ☐		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO. | | | | | | | | |		DAYTIME TELEPHONE NUMBER: EVENING TELEPHONE NUMBER:		

HEALTH COVERAGE ENROLLMENT STATEMENT

This benefit is only available to members covered under a group health benefit plan. This benefit is **not** available if you opted out of the group health benefit plan offered through your employer and are not covered under another group health benefit plan. If you are covered under a plan purchased on an individual basis, including an ACA Exchange plan, this benefit is not available to you.

☐ **I am enrolled in the group health benefit plan provided by my employer**

☐ **I am enrolled in a group benefit plan provided by my spouse's employer**

Employer Name:_____ **Insurance Carrier:**_____ **Group No:**_____

IMPORTANT NOTICE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.

MEMBER SIGNATURE

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED.

REIMBURSEMENTS ARE PAYABLE TO MEMBERS ONLY

_____ SIGNATURE OF MEMBER

_____ DATE