New York City Department of Education - Division of Human Resources
HR Connect Medical, Leaves and Records Administration

Email (Send from your DOE email only): HRConnectMedRequests@schools.nyc.gov Fax: (718) 935-3048

CLAIM FOR REIMBURSEMENT OF MEDICAL EXPENSES (OP 505)

SECTION I: Applicant Information

LAST NAME | FIRST NAME | M.I.

STREET ADDRESS | APT. NUMBER | CITY | STATE | ZIP CODE

AREA — — HOME TELEPHONE NUMBER | FILE NUMBER | EMPLOYEE ID

JOB TITLE: _____ EMAIL ADDRESS: _____

SCHOOL CODE	AREA — — SCHOOL TELEPHONE NUMBER	ISC/CFN	DISTRICT

Date of LODI incident:: _____

Line of duty case #: _____

LODI approved by HR Connect? Yes ☐ No ☐

SECTION II: Itemization of Medical Expenses

ACCIDENT OR ASSAULT (CHECK THE APPROPRIATE
- ☐ 1. ACCIDENT
- ☐ 2. ASSAULT

ACCIDENT OCURRED WHILE IN YOUR VEHICLE
- ☐ 1. YES
- ☐ 2. NO

ABSENT DUE TO INJURY
- ☐ 1. YES
- ☐ 2. NO

1. Are you currently enrolled in a health plan? Yes ☐ No ☐

If yes, provide the name of the health plan in which you are enrolled: _____

Are you enrolled in an optional rider? Yes ☐ No ☐

2. Complete the table below with the requested information. Attach additional sheets of paper, if necessary.
Note: The maximum reimbursable amount for a line of duty accdient or incident claim is $750.

Name of Doctor/Provider	Provider In/Out of Network	Date of Service	Description of Service	Out-of-Pocket Medical Expense (Medical Expenses minus Insurance Reimbursements)

TOTAL AMOUNT

I hereby submit a claim for medical expenses as a result of injuries sustained in the line-of-duty. This claim is made by me and submitted to the Department of Education with the intent that the Department of Education rely thereon in approving and paying my claim.

_____ **Signature of Claimant**

Today's Date

SECTION III: To be completed by Claims Unit ONLY

Today's Date _____ Amount _____ Date Disapproved _____ Reviewed By _____

Instructions for Claim for Reimbursement of Medical Expenses form (OP505)

1. Complete the application on the face of this form per the instructions below.

Section I: To be completed by the applicant

a. Provide your full name, mailing address, home and school contact information, file number, employee ID, job title, and email address

b. In the space next to your school contact information, provide the following information:

i. The date of the Line of Duty Injury (LODI) incident

ii. The LODI case number issued by HR Connect (if applicable)

iii. Check (Yes/No) if your LODI was approved by HR Connect

Note: Your LODI claim must be approved by HR Connect Medical, Leaves and Records Administration BEFORE you submit a claim for reimbursement.

Section II: To be completed by the applicant

c. Check the appropriate box

i. LODI incident was an accident or assault

ii. LODI incident occurred in your vehicle

iii. Absent from duty as a result of LODI incident. If Yes, see Step 2 for instructions on supporting documentation to include with your completed application form.

d. In the space provided, indicate the full name of your DOE health plan and whether you are enrolled in an optional rider (e.g. prescription coverage) as part of your health plan.

e. In the table provided, indicate the folowing:

i. Name of doctor, provider, or service (e.g. Dr. John Doe, medical prescription)

ii. Whether the doctor, provider, or service is in-network (IN) or out-of-network (OUT) for your healthcare provider

iii. Date of service

iv. Description of service

v. Any out-of-pocket medical expenses. This is defined as your portion of medical cost after reimbursement from your health care provider (for example, your insurance deductable or medical insurance co-pay.

Section III: To be completed by the Claims office
Applicants should not complete this section. It is for official use only.

2. Include the following supporting documentation with your application:

a. Detailed bills that reflect the nature of the medical services rendered, pharmaceuticals, or items purchased. Bills for medical services must include the CPT-4 code(s) per office visit and/or per treatment(s), including surgery. Examples include:

+ Anesthesia: How long administered (in hours and minutes)?
+ X-rays and MRIs: What body part(s) was photographed? How many views were taken?
+ Laboratory: What testing was done? Why? [Charge(s) per test MUST be shown]
+ Physical Therapy: Length of session (in hours and/or minutes)
+ Psychotherapy: Length of session (in hours and/or minutes)
+ CPT-4: Physician's Current Procedural Terminology - is a standard classification used to identify and report procedures and services performed by or under the direction of a physician

b. Explanation of Benefits form for each office visit/treatment.

c. Proof of payment. This can be in the form of credit card transaction receipts, cancelled checks, or a copy of the receipt from your medical provider's office that includes the provider's name, nature of the visit, date of service, and form of payment.

d. If you were not absent from work due to your injury, you must include a copy of the Comprehensive Injury Report (CIR) with your application form. This copy - which can be obtained from your payroll secretary or principal - must include the signatures of both your principal and superintendent approving the statement about your injury.

3. Sign and date the form.

4. Submit the completed form and supporting documentation to HR Connect:

New York City Department of Education
HR Connect Medical, Leaves and Records Administration
Email (*Please only send from your DOE email address*): HRConnectMedRequests@schools.nyc.gov
Fax: (*Please do not fax items which have previously been emailed.*) (718) 935-3048