



# WELFARE FUND

52 Broadway, 7<sup>th</sup> Floor  
New York, NY 10004

# GHI DME Durable Medical Equipment Deductible Reimbursement Form

For In-Service GHI-CBP Subscribers Only

Complete and submit this form after the end of the calendar year or when your family deductible reaches \$100, whichever is sooner.

**To Be Completed By Member (Please Print):**

CALENDAR YEAR: _____	Soc. Sec. #: _____
Member's Name: _____	File #: _____
Address: _____	Health Plan: _____
City, State, Zip: _____	School: _____
Telephone #: _____	E-mail Address: _____

Please list the names of the family members with their corresponding amounts in date of service order.  
You must attach an Explanation Of Benefits from GHI listing each amount claimed.

<u>Date(s) of Service</u>	<u>Patient Name*</u>	<u>Relationship*</u>	<u>Date of Birth</u>	<u>Soc. Sec. #</u>	<u>Amount Claimed</u>
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
(Maximum reimbursement is \$100 per family per calendar year)				<b>TOTAL CLAIMED</b>	\$ _____

**\* Must Be Completed If Service Was For Dependent:**

Is spouse/domestic partner covered by another insurance policy?  YES

NO

If yes, name of insurance company: \_\_\_\_\_  
(You must also attach a copy of the Explanation of Benefits from this insurance company)

Policy #: \_\_\_\_\_

**DECLARATION:** To the best of my knowledge, the above information is true and correct and I or my dependent(s) have received the service(s) indicated above. In the event I receive an overpayment of benefits, on my behalf or on behalf of my dependent(s), I am obligated to refund said overpayment to the Fund immediately.

Signature of Member: \_\_\_\_\_ Date: \_\_\_\_\_