UFT

WELFARE FUND

52 Broadway, 7th 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.

Date(s) of Service	Patient Name*	Relationship*	Date of Birth	Soc. Sec. #	Amount Claimed
_____	_____	_____	_____	_____	$_____
_____	_____	_____	_____	_____	$_____
_____	_____	_____	_____	_____	$_____
_____	_____	_____	_____	_____	$_____
_____	_____	_____	_____	_____	$_____

(Maximum reimbursement is $100 per family per calendar year) **TOTAL CLAIMED** $_____

*** 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: _____