



52 Broadway  
New York, NY 10004

# Prescription Appliance and/or Medical Equipment Claim Form

HIP Subscribers Only

**You Must Attach an Itemized, Paid Bill Showing Date and Item Purchased. ORIGINAL BILLS ONLY.**

Note: Subject to a \$25.00 Deductible, per person per calendar year.

***To Be Completed By Member (please print):***

Member's Name: _____	Welfare Fund Alt. ID # or Soc. Sec. #: _____
Address : _____	File #: _____
City, State, Zip: _____	Health Plan: _____
Telephone #: _____	School: _____

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

Dependent's Name: _____	Dependent's Date of Birth: _____
Relationship to Member: _____	Dependent's Soc. Sec. #: _____

Is spouse/domestic partner covered by another insurance policy:  Yes  
 No

If yes, name of insurance company and policy #: \_\_\_\_\_  
(You must also attach a copy of the Explanation of Benefits from that insurance company).

Have you previously submitted ANY claim to the UFT Welfare Fund for this medical condition:  Yes  
 No

**DECLARATION:** To the best of my knowledge, the above information is true and correct and I or my dependent have received the service(s) indicated below. 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: \_\_\_\_\_

***To Be Completed By Physician (please print):***

Appliance prescribed for (Patient's Name): _____	Patient's Date of Birth: _____
Condition warranting Appliance: _____	Date Prescribed: _____
Type of Appliance: _____	HCPCS Code #: _____
Physician's Name: _____	
Physician's Address: _____	
City, State, Zip: _____	
Physician's Telephone #: _____	Signature Of Physician: _____