



52 Broadway  
New York, NY 10004

# Anesthesia Benefit Claim Form

HIP Subscribers Only

Effective July 1, 1983, anesthesia charges are covered in full when admitted to a hospital by an HIP/HMO physician and for emergency illness or accidental injury. However, the UFT Welfare Fund will pay 80% of reasonable and customary charges when not covered by HIP/HMO.

If HIP does not cover your anesthesia charges, you must submit the following:

1. A copy of the HIP "Rejection letter"
2. An itemized, paid bill. ORIGINAL BILLS ONLY.

**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 Expansion of Benefits from that insurance company).

DECLARATION: To the best of my knowledge, the above information is true and correct and I or my dependent have received the service 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 Anesthetist (please print):**

Patient's Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_  
Describe Nature Of Operation: \_\_\_\_\_  
Where Was Surgical Procedure Performed: \_\_\_\_\_  
Anesthetist's Name: \_\_\_\_\_ Circle One: R.N.A. D.O. M.D.  
Anesthetist's Address: \_\_\_\_\_ Time of Surgical Procedure: Hours: \_\_\_\_\_ Minutes: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Charge for Anesthesia: \$ \_\_\_\_\_  
Anesthetist's Telephone #: \_\_\_\_\_ Date Anesthesia Was Administered: \_\_\_\_\_  
Signature Of Anesthetist: \_\_\_\_\_ Surgeon's Or Obstetrician's Name: \_\_\_\_\_