



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: _____ |