



SEE REVERSE SIDE FOR INSTRUCTIONS

PLEASE PRINT OR TYPE

NAME _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____ FILE NUMBER: _____

1. TITLE: _____ 2. SCHOOL/OFFICE: _____

3. SCHOOL/OFFICE ADDRESS: _____

4. DATE OF ASSAULT: _____ 5. NATURE OF INJURY: _____

6. DESCRIPTION OF ASSAULT: (If additional space is needed write on separate sheet and attach to claim)

7. WERE YOU ABSENT DUE TO INJURY? YES NO : If yes, see paragraph 1c of instructions.

8. CHECK HEALTH PLAN CURRENTLY ENROLLED IN AND CHOICE OF OPTIONAL BENEFITS RIDER:

HEALTH PLAN	NO OPTIONAL RIDER	OPTIONAL RIDER	NFT OPTIONAL RIDER
a. <input type="checkbox"/> HIP/HMO	<input type="checkbox"/>	<input type="checkbox"/>	
b. <input type="checkbox"/> MED-PLAN	<input type="checkbox"/>	<input type="checkbox"/>	
c. <input type="checkbox"/> GHI-CBP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. <input type="checkbox"/> GHI-TYPE C	<input type="checkbox"/>	<input type="checkbox"/>	

9. Are you or your spouse enrolled in any Private or Group Health Insurance Plans which provide coverage for any expenses incurred other than in section 8 above? YES NO If yes, please provide the following:

9a. Name of carrier _____

Carrier address _____

Policy holder _____ Policy number _____

9b. Name of carrier _____

Carrier address _____

Policy holder _____ Policy number _____

10. MEDICAL EXPENSES: \$ _____ (see § 1a of instructions)

11. REIMBURSEMENTS: \$ _____ (see § 1e of instructions)

Subtract item 11 from item 10.
Remainder is entered in item 12.

12. AMOUNT CLAIMED: \$ _____

13. I hereby submit a claim for medical expenses as a result of an assault sustained in the line-of-duty. The facts in connection with the injuries are indicated above. This claim is made by me and submitted to the Board of Education with the intent that the Board of Education rely thereon in approving and paying my claim.

SIGNATURE OF CLAIMANT

DATE

14. CERTIFICATE BY PRINCIPAL OR HEAD OF BUREAU

I hereby transmit herewith a claim submitted by _____
to the best of my knowledge, information and belief, the facts contained under paragraphs 1 through 7 are substantially true.

SIGNATURE AND TITLE

DATE

MAKE NO ENTRY BELOW THIS LINE (For Medical Bureau-Claims Unit use only)

Date Approved _____ For Claims Unit: _____

Amount \$ _____

Date Disapproved _____

INSTRUCTIONS FOR OP505

1. Required Enclosures:

- a. Proof of Payment
ie: Either copy of cancelled checks or copy of receipted paid bill on the doctors or vendor letterhead.
- b. Detailed bills that reflect the nature of the medical services rendered and prescriptions for items purchased. (CPT-4 code(s) per office visit and/or per treatment(s), including surgery) (See Below For Examples of Information Needed)
- c. Copy of the OP 198 approved by the Medical Bureau granting line-of-duty status for the period of absence.
- d. Accident and/or incident report.
- e. Notices of reimbursement from GHI, Medicare and private health insurance plans. GHI-CBP subscribers using partipating physicians should include copy of the reimbursement notices sent to their doctors by GHI.

2. Mailing Instructions:

Sign the original OP 505 and one (1) copy. Mail original, copy and enclosures to:

The New York City Board of Education
Division of Personnel
Claims Unit - Medical Bureau
Room 10 - 2nd Floor
65 Court Street
Brooklyn, New York, 11201

EXAMPLES RE PARAGRAPH 1b, ABOVE

1. ANESTHESIA - How long administered (in hours and minutes)?
2. X-RAYS - What body part(s) was x-rayed. How many views were taken?
3. LABORATORY - What testing was done? Why? (Charge(s) per test MUST be shown)
4. PHYSICAL THERAPY - Length of session (in hours and/or minutes)?
5. PSYCHOTHERAPY - Length of session (in hours and/or minutes)?
6. CPT-4 - Physician's Current Procedural Terminology - is a standard classification used to identify and report procedures and services performed by or under the direction of a physician.

NOTE

**INSTRUCTIONS FOR
OP505 and OP505A
ARE IDENTICAL**