Claims must be filed within 1 year of the date of service or payment by health plan, whichever is later.

SHIP Claim Form

UFT/RTC Supplemental Health Insurance Program (SHIP)

Mail to: **SHIP**
52 Broadway, 17th Floor
New York, NY 10004
Telephone: 212-228-9060

Please read reverse side for required documents and benefit limitation before submitting claim. Incomplete claims will be returned and delayed.

Member's Name (last, first) _____

Patient's Name (last, first) _____ **Patient's Birth Date** ___ ___ / ___ ___ / ___ ___ ___ ___
(if member, write "SAME") Month Day Year

Address _____
Apt# City State Zip

Member's Social Security #

___ ___ ___ – ___ ___ – ___ ___ ___ ___

Patient's Social Security #

___ ___ ___ – ___ ___ – ___ ___ ___ ___

Health Plan_____ **Is Patient on Medicare? ____Yes ____No**

Phone# (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Member (or **Spouse** if claim is for spouse) sign below:

X _____ **Date**_____

Signature: (if the Member is deceased/incapacitated please call SHIP at the above telephone number.)

Instructions: A separate SHIP Claim Form is required for Member and Spouse and for each different SHIP benefit.
SHIP Claim Benefit: Enter amount or an "X" in the box to the right of the benefit this claim is for.

1. Accidental Death & Dismemberment		9. Nurse's/Home Health Aides (at home only)	
2. Ambulance/Ambulette/WAV		10. Orthopedic Shoes/Orthotics	
3. Blood Bank		11. Prescription Drugs** (Medicare/Medicaid eligible enrollees are NOT entitled to Drug benefit.)	
4. Dental Stipend**			
5. Emergency Alert System**		12. Private Duty Nursing (in hospital only)	
6. Hairpiece, Wig or Cold Cap Therapy		13. Psychiatric Hospitalization	
7. Hearing Aid – **Note:** UFT Welfare Fund member see back for details		14. Surgical Stockings/Sleeves/ Compression Wraps**	
8a. Hospital Deductible (in-patient)		15. Survivor Benefit (SHIP's COBRA premium is free.)	
8b. Emergency Room (ER co-pay)		16. Surgery/Anesthesia	

****One (1) claim allowed for this SHIP benefit per calendar year, sign waiver on back if less than benefit maximum.**

DO NOT WRITE IN AREA BELOW (SHIP USE ONLY)			**Name/Initial**	**Date**
SHIP Plan:		Date Received:		
Effective date of plan:		Claims Processor:		
Comment/Reason for Rejection:				

Photocopies of this Claim Form are accepted. **SHIP Claim Form Revised Jan. 2020** GP27948

Claims MUST be filed within 1 year from date of service or date of payment by health plans, whichever is later. SHIP is a reimbursement program and will NOT pay providers directly. All claims paid to the member.

CSA/RSSA: If spouse is covered by CSA/RSSA, spouse must file claims with CSA first and UFT member must file claims with SHIP first. ALL health plan(s) including Long Term Care (LTC) are primary to SHIP except NYSUT Catastrophic, which is secondary to SHIP.

Listed Below are the document(s) required and limitations to process a claim, see SHIP brochure for further details.

All claims require: Item a. SHIP Claim Form which "MUST" be signed and completed.

1. Accidental Death & Dismemberment
$10,000 maximum, benefit expires at age 80

2. Ambulance/Ambulette/WAV ($300 Calendar year limit)
b. Copy of invoice/bill with proof of payment
c. Copy of insurance(s) Explanation of Benefits (EOB) or proof of medical necessity

3. Blood Bank ($500 Calendar year limit)
b. Copy of invoice/bill with proof of payment
c. Copy of insurance(s) Explanation of Benefits (EOB)

4. Dental Stipend ($300 Calendar year limit)
b. Copy of Welfare Fund Dental Benefits Summary and other Dental carrier if applicable
c. Copy of proof of payment
***Warning: see Waiver below**

5. Emergency Alert System (1 claim per calendar year)
b. Copy of AMA invoice(s) with proof of payment
c. Proof of In-patient (admitted overnight) hospital stay

6. Hairpiece, Wig or Cold Cap Therapy ($300 every 3 years, $600 LIFETIME)
b. Copy of invoice/bill with proof of payment
c. Physician's note stating ailment and treatment
Limitation: Hair loss (alopecia) due to medical treatment

7. Hearing Aid ($1,500 every 3 years)
Note: UFT Welfare Fund (WF) member: file WF Hearing Aid Benefit form to receive WF benefit and 2 weeks later receive SHIP benefit.
Not a WF member: send SHIP Claim Form directly to SHIP along with physician's note stating need, invoice and proof of payment

HOSPITAL DEDUCTIBLES:

8a. In-Patient: ($300 maximum per stay, $750 per calendar year)
b. Copy of invoice/bill with proof of payment, (invoice/bill MUST show date(s) of hospitalization)

8b. Emergency Room: ($150 maximum co-pay, 2 per year)
b. Copy of invoice/bill with proof of payment, (invoice/bill MUST show date(s) of hospitalization)

9. Nurse's Aide(s) (at home only)
b. Physician's note stating ailment, necessity and duration
c1. Proof of hospital stay of 3 or more consecutive days
c2. Proof of rehab stay (if applicable)
d. Copy of invoice showing service period and amount billed
e. Proof of payment (No cash payments-see details on right)
f. If insured-copy of insurance(s) Explanation of Benefits
g. Copy of State Certificate for nursing agency
Benefit: SHIP pays 50% of out-of-pocket cost for at-home nursing aides up to a maximum $1,250 month for 6 months **$20,000 LIFETIME**
Benefit NOT available during first year of enrollment.
WARNING: GAP OF 10 DAYS WITHOUT AIDE TERMINATES BENEFIT

10. Orthopedic Shoes/Orthotics ($300 Calendar year limit, $2,000 LIFETIME)
b. Copy of invoice/bill with proof of payment
c. Physician's note stating ailment and necessity
Limitation: Must be NEW "Custom made" or "Customized"

11. Prescription Drugs ($1,000 Calendar year limit)
b. Copy of insurance(s) statement for entire calendar year or sign waiver below accepting partial year. Statement "MUST" show for each individual drug: **Date, Drug Cost, Amount paid by insurance and member**
Benefit: AFTER a $500 calendar deductible, SHIP reimburses 100% of eligible drugs paid by member up to $1,000 MAXIMUM. Drug MUST be partially covered by insurance to be eligible for benefit
Limitation: Medicare/Medicaid enrollee/eligible NO benefit
***Warning: see Waiver below**

12. Private Duty Nursing (in Hospital only, $2,125 maximum)
b. Copy of invoice/bill with proof of payment
c. Copy of insurance(s) Explanation of Benefits (EOB)
Limitation: Insurance MUST provide coverage to be eligible for benefit

13. Psychiatric Hospitalization ($2,500 Calendar year limit)
b. Copy of invoice/bill with proof of payment
c. Copy of insurance(s) Explanation of Benefits (EOB)
Limitation: Insurance MUST provide first 30 days coverage

14. Surgical Stocking/Sleeves/Compression Wraps ($200 Calendar year limit, $2,000 LIFETIME)
b. Copy of invoice/bill with proof of payment
c. Physician's note stating ailment and necessity
***Warning: see Waiver below**

15. Survivor Benefit (SHIP's COBRA premium is free)
b. Copy of UFT retiree/retired employee Death Certificate
Note: You MUST notify SHIP NO LATER THAN 90 DAYS after date of death

16. Surgery/Anesthesia
b. Copy of invoice/bill with proof of payment
c. Copy of insurance(s) Explanation of Benefits (EOB)
Limitation: Insurance MUST provide coverage to be eligible for benefit. $500 SHIP deductible (One [1] procedure per year, $5,000 maximum)

CLAIM PROCEDURES:

A separate Claim Form is required for Member and Spouse and for each different benefit. Claim Form MUST be completed and signed. Photocopies of documents are accepted, originals will **NOT** be returned.

Acceptable proof of payment:
Cancelled check, bank check, credit card receipt/statement

NOT accepted as proof of payment:
Handwritten or stamped "PAID" on receipt/invoice

Nurses's Aides proof of payment:
1. Check or credit card payment MUST be payable to nursing agency
2. **NO cash payment receipts accepted**
3. Payment MUST be within 60 days of STARTING date of service, State Certified family member or free service is NOT allowed without PRIOR written consent

***Waiver: Applies to benefits with 1 claim submission per calendar year and claim is for less than benefit maximum. By accepting I am aware I have exhausted this benefit and cannot submit another claim for the same calendar year.**

Benefit/Amount _____ **Signature** _____ **Date** _____