UFT
WELFARE FUND
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 Explanation 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: _____