UFT
WELFARE FUND
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: _____