

PLAN ADMINISTERED BY

POMCO

# OSSINING UNION FREE SCHOOLS HEALTH PLAN

RETURN TO:

POMCO  
P.O. BOX 6329  
SYRACUSE, NY 13217  
1-800-733-8144

MEDICAL/SURGICAL/MAJOR MEDICAL BENEFIT REQUEST FORM

## PATIENT INFORMATION SECTION

|   |  |  |                       |   |   |   |
|---|--|--|-----------------------|---|---|---|
| 1. PATIENT NAME   |  | 2. RELATIONSHIP TO EMPLOYEE<br>SELF   SPOUSE   CHILD   OTHER |                       | 3. SEX<br>M   F   | 4. PATIENTS DATE OF BIRTH<br>MONTH   DAY   YEAR |   |
| 5. IF FULL TIME STUDENT GIVE NAME AND ADDRESS OF SCHOOL AND YEAR OF GRADUATION  |  |  |                       |   |   |   |
| 6. EMPLOYEE NAME<br>FIRST   MIDDLE   LAST   |  |  |                       | 7. EMPLOYEE MEMBER ID#  |   |   |
| 8. EMPLOYEE MAILING ADDRESS   |  |  | EMPLOYEE'S BIRTH DATE | 9. EMPLOYER<br><b>OSSINING UNION FREE SCHOOLS<br/>Plan 680</b>  |   |   |
| CITY, STATE, ZIP  |  |  |                       | 10. IS TREATMENT A RESULT OF AN AUTO ACCIDENT?<br><input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, GIVE DESCRIPTION AND DATE. |   |   |
| 11. IS THE TREATMENT A RESULT OF AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES PLEASE DESCRIBE. HOW, WHEN AND WHERE?   |  |  |                       |   |   | IS TREATMENT DUE TO A WORK-RELATED CONDITION?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 12. IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | SPOUSE'S NAME  |                       | SPOUSE'S BIRTH DATE   | SPOUSE'S MEMBER ID#                             |   |
| 13. NAME, ADDRESS AND PHONE NUMBER OF SPOUSE'S EMPLOYER   |  |  |                       |   |   |   |
| 14. IS THE PATIENT, YOUR SPOUSE, YOURSELF, OR ANY OTHER FAMILY MEMBER COVERED BY ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ANSWER QUESTION 15. NAME OF FAMILY MEMBER COVERED  |  |  |                       |   |   |   |
| 15. HEALTH PLAN NAME  |  | GROUP NUMBER   |                       | NAME AND ADDRESS OF OTHER HEALTH INSURANCE COMPANY  |   |   |
| 16. I CERTIFY THE INFORMATION GIVEN BY ME IS COMPLETE AND CORRECT, AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE PATIENT NAMED. I AUTHORIZE ANY PHYSICIAN OR HOSPITAL TO PROVIDE PERTINENT RECORDS TO POMCO UPON REQUEST TO ESTABLISH MY CLAIM FOR BENEFITS UNDER THIS PLAN. |  |  |                       |   |   |   |
| SIGNATURE OF COVERED EMPLOYEE   |  |  |                       | DATE  |   |   |
| 17. I AUTHORIZE POMCO TO PAY ANY BENEFITS DUE TO THE PROVIDER I HAVE INDICATED.   |  |  |                       |   |   |   |
| SIGNED (EMPLOYEE)   |  | DATE   |                       | PLEASE PAY DR.  |   |   |

## PHYSICIAN OR PROVIDER INFORMATION (SEE REVERSE FOR INSTRUCTIONS)

| 18. ONSET OF INJURY OR ILLNESS   |                       | 19. DATE FIRST CONSULTED BY YOU FOR THIS CONDITION |                         | 20. IF EMERGENCY ILLNESS OR INJURY, BRIEFLY DESCRIBE.                                 |     |  |
|--|-----------------------|--|-------------------------|---|-----|--|
| <b>PLACE OF SERVICES CODES</b><br>H - HOSPITAL      O - OFFICE VISITS      L - LAB<br>OP - OUTPATIENT      X - OTHER |                       |  |                         | 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY  |     |  |
| DATE OF SERVICE  | PLACE OF SERVICE CODE | DIAGNOSTIC CODE (ICD,DSM)                          | PROCEDURE CODE (CPT- 4) | FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN | FEE |  |
|  |                       |  |                         |   |     |  |
|  |                       |  |                         |   |     |  |
|  |                       |  |                         |   |     |  |
|  |                       |  |                         |   |     |  |
|  |                       |  |                         |   |     |  |
|  |                       |  |                         |   |     |  |
| PROVIDER NAME AND ADDRESS  |                       |  |                         | TOTAL FEE CHARGED   |     |  |
| CITY, STATE, ZIP   |                       |  |                         | AMOUNT PAID   |     |  |
| TAXPAYER IDENTIFICATION NUMBER   |                       |  |                         | BALANCE DUE   |     |  |

I HEREBY CERTIFY THAT THE PROCEDURES INDICATED BY DATE HAVE BEEN COMPLETED.

DOCTOR'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_

EMPLOYEE

PHYSICIAN

# **OSSINING UNION FREE SCHOOLS**

## **HOW TO REQUEST BENEFITS**

1. COMPLETE ITEMS 1 THROUGH 10 UNDER THE PATIENT INFORMATION SECTION. IF YOU ARE MARRIED, OR HAVE OTHER HEALTH BENEFITS, ITEMS 12,13,14, AND 15 MUST BE COMPLETED. IF ANY INFORMATION IS MISSING, IT WILL DELAY THE PAYMENT OF YOUR CLAIM.
2. HAVE YOUR DOCTOR COMPLETE THE PHYSICIAN'S INFORMATION SECTION, OR SUBMIT COMPLETELY ITEMIZED BILLS. AN ITEMIZED BILL MUST CONTAIN: PATIENT'S NAME, RELATIONSHIP, DATE OF SERVICE, TYPE OF SERVICE RENDERED, NATURE OF CONDITION BEING TREATED. IF THIS INFORMATION IS MISSING, YOU MAY WRITE IT ON THE BILL, AND SIGN YOUR NAME. IF YOU GO TO A NON-PARTICIPATING PHARMACY OR DO NOT USE YOUR PRESCRIPTION DRUG CARD, COMPLETE A SEPARATE PRESCRIPTION DRUG CLAIM FORM.
3. IF YOU WANT BENEFITS PAID TO YOUR DOCTOR, OR PROVIDER DIRECTLY, BE SURE TO SIGN ITEM 17.
4. COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER.
5. THE COMPLETED CLAIM FORM SHOULD BE RETURNED TO:

POMCO  
P.O. BOX 6329  
SYRACUSE, NY 13217

**TOLL FREE NUMBER 1-800-733-8144**

**IMPORTANT REMINDER:**  
PLEASE BE SURE THE EMPLOYEE'S MEMBER ID# HAS BEEN PROVIDED.

# **POMCO®**

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACTUAL MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME"