SERGEANTS BENEVOLENT ASSOCIATION

35 Worth Street
New York, NY 10013
212-431-6555 (Phone) / 212-431-6487 (Fax)

CATASTROPHIC COVERAGE BENEFIT CLAIM FORM
INSTRUCTION INFORMATION

Once you have met the $2000.00 deductible, complete the attached SBA Catastrophic Coverage Claim Form. Submit the completed form together with copies of all health plan "Explanation of Benefit" (EOB) forms (including any Coordination of Benefits EOBs), Current Procedural Terminology (CPT) codes (if not included on EOB), and paid bills/canceled checks to the SBA Fund office in a timely manner. Please notify the SBA Fund office if there is a delay in submitting the claim. A separate claim form must be filed for each eligible dependent. This is a reimbursement benefit. Members are responsible for payment to their medical providers.

COORDINATION OF BENEFITS

The SBA Catastrophic Coverage Benefit was designed to assist our Members meet the cost of financially distressing illness, injury or disease. Since it is not intended that any member receive greater benefits than the actual incurred covered expenses, the amount of benefits paid will be coordinated with the benefits of any other Plan to which the Member or eligible dependent is entitled to receive benefits.

EXCLUDED EXPENSES

a. This benefit *does not cover* prescription drugs, workers compensation benefit claims, occupational injury, illness or disease, dental work, cosmetic surgery, fertility treatments, transportation, no fault auto insurance medical expenses, experimental procedures, any medical, surgical or hospital service/charge *not approved* for payment by a Member's Participating Provider Organization (PPO) or Point of Service Plan (POS).
b. Services and supplies that are unreasonably priced or that are not reasonably necessary for treatment of an injury, illness or disease.
c. Expenses caused or services not ordered by a physician or surgeon who is a Doctor of Medicine (M.D.) and duly licensed to practice medicine.

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SBA CATASTROPHIC COVERAGE CLAIM FORM

MEMBER'S INFORMATION

NAME: FIRST ______________________ MI ________ LAST ______________________

MAILING ADDRESS: STREET ____________________ CITY ______________ STATE_____ ZIP________

TAX ID#: ___ ___ ___ ___ ___ ___ PHONE NUMBER: _______-________-________________

PATIENT'S INFORMATION

NAME: FIRST ______________________ MI ________ LAST ______________________

MAILING ADDRESS (If different from above):

STREET ______________________ CITY ________________ STATE________ ZIP__________

DATE OF BIRTH: ____/_____/______ SOCIAL SECURITY #: ______-_____-_______ RELATIONSHIP: _____________

CATASTROPHIC INFORMATION

DIAGNOSIS: ____

HAS THE SBA HEALTH & WELFARE FUND EVER PAID A CATASTROPHIC COVERAGE CLAIM FOR THIS PATIENT? (CIRCLE ONE): YES NO

AMOUNT OF BENEFIT PAID: $ __________________ YEAR OF PAYMENT: ________________

HEALTH COVERAGE INFORMATION

MEMBER'S NYC HEALTH PLAN: __________________ HEALTH PLAN ID #: __________________

IS THE PATIENT COVERED BY ANY OTHER HEALTH INSURANCE PLAN? (CIRCLE ONE): YES NO

IF "YES", PLEASE PROVIDE THE FOLLOWING INFORMATION:

OTHER INSURED'S NAME: FIRST __________________ MI ______ LAST ____________________

OTHER INSURANCE PLAN NAME: ____________________ OTHER HEALTH PLAN ID #: ____________

THE FOLLOWING DOCUMENTS/INFORMATION MUST ACCOMPANY THIS FORM: ALL HEALTH PLAN EXPLANATION OF BENEFIT (EOB) FORMS, CPT CODES (IF NOT INCLUDED ON EOB) AND COPIES OF PAID BILLS/CANCELLED CHECKS.

MEMBER'S SIGNATURE

I DO HEREBY STATE THAT ALL THE INFORMATION I HAVE ENTERED ABOVE IS CORRECT.

MEMBER'S SIGNATURE: ______________________________________ DATE: ________________