Management Benefits Fund

Superimposed Major Medical Plan (SMMP) Claim Form

A. MEMBER INFORMATION

SOCIAL SECURITY NUMBER ___ - ___ - ___ DATE OF BIRTH ___ / ___ / ___ ☐ ACTIVE ☐ RETIRED ☐ COBRA ☐ SURVIVOR ☐ LTD DISABLED DATE (IF APPLICABLE) ___ / ___ / ___

LAST NAME FIRST NAME MI

ADDRESS WORK TELEPHONE NUMBER

CITY STATE ZIP CODE HOME TELEPHONE NUMBER

CITY HEALTH PLAN NAME

PRESCRIPTION DRUG COVERAGE: ☐ YES ☐ NO **PLEASE ATTACH COPIES OF ALL HEALTH PLAN IDENTIFICATION CARDS**

IS THERE ANY OTHER COVERAGE? ☐ NO ☐ YES **(IF YES, YOU MUST LIST ALL OTHER COVERAGES, INCLUDING MEDICARE COVERAGE**

	ID NUMBER	PLAN NAME AND PLAN NUMBER	PLAN EMPLOYER OR SPONSOR
MEMBER			
SPOUSE/DOMESTIC PARTNER			
SPOUSE/DOMESTIC PARTNER (ADDITIONAL COVERAGE IF ANY)			
CHILD			

B. PATIENT INFORMATION (If other than member)

SOCIAL SECURITY NUMBER ___ - ___ - ___ DATE OF BIRTH ___ / ___ / ___ ☐ SINGLE ☐ MARRIED ☐ EMPLOYED

LAST NAME FIRST NAME MI

PATIENT RELATIONSHIP TO MBF MEMBER: ☐ SPOUSE/DOMESTIC PARTNER ☐ CHILD

PATIENT CONDITION IS RELATED TO : **EMPLOYMENT** ☐ YES ☐ NO **AUTO ACCIDENT** ☐ YES ☐ NO **OTHER ACCIDENT** ☐ YES ☐ NO

C. CLAIM INFORMATION

THIS SECTION MUST BE COMPLETED *ONLY* IF AN ITEMIZED STATEMENT FROM THE PROVIDER IS NOT PROVIDED.

DATES OF SERVICE FROM	DATES OF SERVICE TO	PLACE OF SERVICE	CPT/HCPCS	PROCEDURES, SERVICES, OR SUPPLIES	MODIFIER	UNITS	DIAGNOSIS CODE	CHARGES
								$
								$
								$
								$
								$

FEDERAL TAX I.D. #: (SS#/EIN) LICENSE NUMBER DEGREE TELEPHONE NUMBER

PROVIDER NAME TOTAL CHARGE

PROVIDER ADDRESS - NUMBER AND STREET AMOUNT PAID

CITY STATE ZIP CODE BALANCE DUE

SIGNATURE OF PROVIDER DATE ___ / ___ / ___

D. MEMBER/PATIENT'S SIGNATURE AND RELEASE (Member must sign all claims, if not a minor, dependent patient must also sign.)

I hereby apply for benefits and certify that the above information is complete, true and correct. I authorize all physicians and other medical professionals, hospitals and other medical care institutions, and insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators to provide ASO and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on ASO's behalf, with information concerning medical care, advice, treatment or supplies provided to the Patient, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photostatic copy of this authorization is as valid as the original.

Claim cannot be processed without member's signature.

MEMBER'S SIGNATURE DATE ___ / ___ / ___

PATIENT'S SIGNATURE (if other than member, and if patient is not a minor) DATE ___ / ___ / ___

ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY FUND OR INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING FALSE, OR MISLEADING INFORMATION, MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE BY LAW.

MAIL CLAIMS TO: MBF SMMP CLAIMS • ASO, INC. • P.O. BOX 9009 • LYNBROOK, NY 11563-9009

Please refer to the SMMP section of the MBF Benefits Booklet available on MBF's Web site at nyc.gov/html/olr for a general list of covered expenses, exclusions, limitations and maximums for both SMMP and Adult Wellness Benefit.

The **SMMP** provides supplemental coverage for qualifying out-of-pocket medical expenses, which remain after all other health coverage allowances have been applied.

The **Adult Wellness Benefit** provides coverage for members and their spouse/domestic partner for periodic routine physicals and screening examinations to promote prevention, early detection, and early intervention of disease. In keeping with this philosophy, services covered under the Adult Wellness Benefit Program will not be subject to a deductible.

Please note: If you have basic coverage for certain services through in-network providers only and/or if you must precertify services, you must comply with the provisions of your basic plan. If you do not, your coverage under the SMMP will be affected.

HOW CLAIMS SHOULD BE SUBMITTED: Out-of-pocket covered medical expenses should be submitted as they are incurred or within 24-months from the date of service(s).

Please note: The SMMP claim form must be completely filled out and submitted with the necessary documentation. Failure to complete the claim form properly may result in the pending of the claim. Only actual remaining out-of-pocket expenses will be considered for payment. Proof of payment, or verification of remaining out-of-pocket expenses if proof of payment cannot be obtained, is required. Payment will be made to the member, NOT to the provider.

1. Submit medical bills to your health plan(s) (primary, secondary, etc) for payment (or to apply charges toward a deductible or co-insurance). Computer generated forms from a provider may not be acceptable.

Please note: If you are a participant in the Health Benefits Buy-Out Waiver Program, you are covered for primary health benefits either under your spouse's/domestic partner's plan or through other employment. Medical expenses must first be submitted to the other plans for payment.

2. If you are covered under both the City's Health Benefits Program and a spouse's/domestic partner's plan (or a plan through other employment), medical bills must be submitted to **both** plans before you submit the bill under the SMMP.

3. Compile all itemized bills generated from your health care provider related to claims.
   a) Your documents must include the diagnosis codes and CPT procedure codes. These codes must be identified with the procedure and other required information on the claim form in Section C-"Claim Information." If they are not included, your claim will be pended until this information is received.
   b) Outpatient mental health claims also require all of the information requested in Section C - "Claim Information" on the claim form. Incomplete statements of rendered services submitted on provider letterhead are not acceptable and will be pended until the required information is received.
   c) IF AN ITEMIZED STATEMENT FROM THE PROVIDER CONTAINING ALL THE INFORMATION REQUIRED IS ATTACHED, THEN IT IS NOT NECESSARY TO COMPLETE SECTION C.

4. Compile the Explanation of Benefits (EOB) statements provided by all health plan(s) under which you have coverage in reference to the above itemized bills.

5. If you have prescription drug coverage through one or more of the health plan(s) under which you are covered, please include a copy of each drug card.

6. Include proof of payment (i.e., receipts and cancelled checks) for out-of-pocket expenses.

7. Submit claim form and all documentation to:

MBF SMMP CLAIMS
Administrative Services Only (ASO), Inc.
P.O. Box 9009
Lynbrook, NY 11563-9009
Toll free: (877) 844-SMMP (7667)