Health and Welfare Fund
Police Benevolent Association of the City of New York
125 Broad Street, 11th Floor, New York, NY 10004
Phone: (212) 349-7560 Fax: (212) 437-9480

CATASTROPHIC CLAIM FORM

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING THIS FORM

THIS CLAIM IS FOR SERVICES RENDERED IN CALENDAR YEAR 20 ____

Section I — MEMBER'S INFORMATION

SOCIAL SECURITY NUMBER	FULL NAME (Last) (First) (MI)		
HOME ADDRESS (NO. AND STREET)	CITY	STATE	ZIP CODE
GHI CATEGORY CODE (FromGHI Card)	HOME PHONE NUMBER	WORK LOCATION (Command)	WORK PHONE NUMBER

Section II — SPOUSE'S INFORMATION

SOCIAL SECURITY NUMBER	FULL NAME (Last) (First) (MI)
CURRENT WORK STATUS ❑ Employed ❑ Retired ❑ Unemployed As Of ___/___/___	NAME OF EMPLOYER (Current or Last)
EMPLOYER'S ADDRESS	

FOR OFFICE USE ONLY Optional Rider ❑ NO ❑ YES Effective Date _____

Section III — PATIENT'S INFORMATION

	SS NUMBER	DATE OF BIRTH	SEX M = MALE F = FEMALE	NAME	RELATIONSHIP TO MEMBER	FULL TIME STUDENT
1.						❑ NO ❑ YES
2.						❑ NO ❑ YES
3.						❑ NO ❑ YES
4.						❑ NO ❑ YES
5.						❑ NO ❑ YES

I HEREBY STATE THAT ALL THE INFORMATION I HAVE LISTED ABOVE IS TRUE, AND I AM ATTACHING ALL THE ITEMIZED MEDICAL BILLS AND GHI STATEMENTS I HAVE RECEIVED.

MEMBER'S SIGNATURE _____ **DATE:** _____

PLEASE READ INSTRUCTIONS AND SIGN AUTHORIZATION FOR RELEASE OF INFORMATION ON REVERSE SIDE

THE **CATASTROPHIC BENEFIT** IS AVAILABLE TO ALL ACTIVE POLICE OFFICERS, OF THE HEALTH AND WELFARE FUND, OF THE POLICE BENEVOLENT ASSOCIATION AND THEIR ELIGIBLE DEPENDENTS THAT MEET THE FOLLOWING CRITERIA:

- **THE MEMBER MUST BE ENROLLED IN GHI THROUGH THE CITY OF NEW YORK HEALTH INSURANCE PROGRAM**
- **THE GHI-CBP PROGRAM MUST BE UNDER THE PBA GROUP**
- **THE MEMBER(INCLUDING ALL DEPENDENTS)HAS INCURRED AN OUT OF POCKET EXPENSE OF $1,500.00 OR $1,250.00 IF THE MEMBER IS ENROLLED IN THE OPTIONAL RIDER BENEFIT, FOR ANY CALENDAR YEAR**
- **THE MEMBER MUST BE ABLE TO PROVIDE ITEMIZED BILLS AND ORIGINAL GHI EXPLANATION OF BENEFITS FOR ALL CHARGES BEING SUBMITTED**
- **ALL CLAIMS SHOULD BE FILED WITHIN ONE (1) YEAR OF THE DATE OF SERVICE**

HOW TO FILE A CATASTROPHIC CLAIM:

WHEN THE MEMBER BELIEVES THEIR OUT OF POCKET EXPENSES FOR A CALENDAR YEAR WILL EXCEED THE CATASTROPHIC DEDUCTIBLE ($1,250.00/$1,500.00) THE MEMBER SHOULD:

- **COMPLETE THE CATASTROPHIC CLAIM FORM**
  - **COMPLETE THE YEAR YOU ARE FILING THE CLAIM FOR**
  - **THEN COMPLETE:**
    - THE MEMBER INFORMATION
    - THE SPOUSAL INFORMATION (IF YOU ARE MARRIED YOU **MUST** COMPLETE THE SPOUSE'S INFORMATION)
    - THE PATIENT INFORMATION (COMPLETE FOR ALL PATIENTS INCLUDING THE MEMBER AND/OR SPOUSE)
  - SIGN AND DATE THE CLAIM FORM
  - SIGN AND DATE THE AUTHORIZATION TO RELEASE INFORMATION
- **ATTACH COPIES OF ALL ITEMIZED PROVIDER BILLS**
  - **ITEMIZED BILLS MUST CONTAIN:**
    - PROVIDER'S NAME AND ADDRESS
    - PROVIDERS TAX ID NUMBER
    - DATE OF SERVICE
    - TYPE OF SERVICE
    - CPT CODE FOR THE SERVICE
    - PROVIDER'S FEE FOR THE SERVICE
- **ATTACH ALL GHI EXPLANATION OF BENEFITS (EOB)**
- **IF MEMBER, PATIENT AND/OR SPOUSE HAS OTHER MEDICAL COVERAGE, ATTACH COPIES OF THE EXPLANATION OF BENEFITS TO INCLUDE REJECTIONS, IF APPLICABLE**
- **MAIL THE COMPLETED CLAIM FORM WITH THE BILLS AND VOUCHERS TO:**

PBA FUNDS OFFICE
CATASTROPHIC BENEFIT CLAIMS
125 BROAD STREET, 11th FLOOR
NEW YORK, NY 10004

YOU MAY FILE ADDITIONAL BILLS AND VOUCHERS FOR THE SAME YEAR AS YOU RECEIVE THEM

THE FUNDS OFFICE RESERVES THE RIGHT TO REQUEST ANY ADDITIONAL DOCUMENTATION NEEDED TO PROCESS THE CLAIM AND SHALL MAKE PAYMENT DIRECTLY TO THE MEMBER ONLY AFTER SUBSTANTIATING THAT THE PROPER PAYMENTS FROM ALL SOURCES INCLUDING GHI HAVE BEEN SECURED

Authorization to Release Information

I Authorize any Healthcare Provider, Insurance Company, Employer, or Self-Insured Entity to release any information regarding the medical benefits or employment information to the PBA Funds Office, for the purpose of validating and determining benefits. This authorization or copy shall be valid for One (1) year from date of Signature:

Member's Signature: _____ **Date:** _____