Co-Insurance/Co-Payment Reimbursement

MAIL CLAIM TO:
Wappingers Congress of Teachers Welfare Trust Fund
C/o Daniel H. Cook Associates
253 West 35th Street- 12th Floor, New York, New York 10001
(914) 250-0700

Patient's Name	**Relationship to Member** Self Spouse Child Other ☐ ☐ ☐ ☐	**Sex** ☐ M ☐ F	**Patient's Date of Birth** Month Day Year	**Policyholder/Subscriber ID #**
Member's Last Name	**First Name**	**Initial**		**Email address:**
Full Mailing Address	No. and Street	Apt. No.		Home Phone ( )
City	**State**			**Zip**

BENEFITS ARE PAYABLE TO MEMBER ONLY

I certify that the information given is correct and authorize release of any information necessary to process this claim. Benefits are not available under any other group plan except as indicated.

MEMBER SIGN HERE _____ **DATE** _____

TOTAL AMOUNT SUBMITTED_____

This benefit is a FAMILY BENEFIT for any in-network coinsurance and /or co- payment costs incurred under the DEHIC Empire Blue Cross Blue Shield Healthy Advantage PPO and EPO 20 Plan.

Your claim must be submitted by March 31st of the calendar year following the calendar year during which your coinsurance and /or co-payment expenses were incurred. Please complete only one claim form per family and attached all covered family members Claims Summary.

<u>To file this benefit:</u>

Attach copies of all explanation of benefits documents received from Empire Blue Cross Blue Shield verifying your coinsurance and/or co-payment expenses for the claim period. All claim forms must contain a total dollar amount otherwise it will be returned to you without payment.