

RETURN TO:
 ADMINISTRATIVE SERVICES ONLY, INC.
 Department 66-H
 PO Box 9005
 Lynbrook, NY 11563
 (516) 396-5500 / (718) 204-7172



ASSISTANT DEPUTY WARDENS DEPUTY WARDENS ASSOCIATION

ACTIVE RETIREE



HOSPITAL INCOME CLAIM FORM

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name:	Birth Date:	Social Security #: (Last 4 digits) XXX-XX-	Relationship to Member: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>
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MEMBER/EMPLOYEE INFORMATION

Member Name:	Birth Date:	Social Security #: (Last 4 digits) XXX-XX-
Street Address:	City:	State: Zip Code: Telephone #:
Email: (Non-DOC)	Work Location:	Work Telephone #:

SPOUSE INFORMATION

Spouse's Name: (Print)	Birth Date:	Social Security #: (Last 4 digits) XXX-XX-	Is spouse covered by another Benefits Plan? YES <input type="checkbox"/> NO <input type="checkbox"/>
Name, Address, Telephone # of Spouse's Employer: (MUST BE COMPLETED OR CLAIM WILL BE RETURNED)		Name of Benefit Plan:	
ARE ANY OTHER BENEFITS AVAILABLE FOR THIS PATIENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		IS THIS AN HMO PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>	

PROVIDER INFORMATION

Provider's Name (Print)	Telephone #		
Address	City	State	Zip Code
Name of Hospital where confined:	Telephone #		
Address	City	State	Zip Code
Is this claim the result of:	Accident or Injury? YES <input type="checkbox"/> NO <input type="checkbox"/>	Occupational Injury? YES <input type="checkbox"/> NO <input type="checkbox"/>	

DID CONFINEMENT OCCUR WHILE THIS PERSON WAS ON ACTIVE DUTY (OR ACTIVE DUTY STATUS) IN THE U.S. ARMED FORCES (ARMY, NAVY, AIR FORCE, MARINES OR COAST GUARD)? YES NO

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Assistant Deputy Wardens Deputy Wardens Association or its designated agent to release all information with respect to myself or any of my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct. Authorization must be signed or payment will not be made.

Signed (Patient, or Parent if Minor): _____ DATE: _____

ASSIGNMENT OF BENEFITS:
I hereby authorize payment of the benefits (otherwise payable to me). I understand I am financially responsible for charges not covered by this authorization.

Signed (Member): _____ DATE: _____

CERTIFICATE OF CONFINEMENT

Check One (✓)		Completed by: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ATTENDING PHYSICIAN	
Patient Name: (Print)	Age:	Date Admitted:	Date Still Confined: Date Discharged:
Diagnosis from Records:			
Date of any previous confinement: From:	To:	Is condition due to any occupational cause: YES <input type="checkbox"/> NO <input type="checkbox"/>	
Completed By: (Name)		Title:	Date Information was taken from records:
Address:		Signature:	
City:	State:	Zip Code:	Date:

PLEASE ATTACH:
 1. A COPY OF THE HOSPITAL BILL WITH PATIENT NAME AND DATE OF SERVICE.
 2. EXPLANATION OF BENEFITS FROM BASE MEDICAL PLAN.

FOR OFFICE USE ONLY	Check #:
VERIFICATION SIGNATURE: _____ DATE: ____ / ____ / ____	Check Issued Date: ____ / ____ / ____