

## PRESCRIPTION REIMBURSEMENT CLAIM FORM

### INSTRUCTIONS

THIS SIDE OF THE FORM MUST BE COMPLETED IN FULL. Attach this form to itemized bills for all expenses being claimed. The bills must show: Patient's Name, Type of Service, Date(s) of Service(s), and the Total Charge. If you are submitting a surgical bill or if the bills are for a major illness, accident, or hospitalization the reverse side of this form must be completed by the attending physician. **AVOID DELAY - ANSWER ALL QUESTIONS.**

### EMPLOYEE INFORMATION

EMPLOYMENT STATUS  ACTIVE  RETIRED  LAID OFF  
 DISABILITY LEAVE  OTHER

EMPLOYEE NAME: (PLEASE PRINT FIRST NAME, MIDDLE INITIAL, LAST NAME)		SOCIAL SECURITY NO.	MARITAL STATUS	
STREET ADDRESS: (STREET, CITY, STATE, ZIP CODE)			<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGALLY SEPARATED	
EMPLOYER'S NAME <b>Cooper Union</b>			DATE OF BIRTH: MONTH/DAY/YEAR	
			GROUP NO. <b>CN</b>	

### DEPENDENT'S INFORMATION: (Complete Only If Patient Is A Dependent)

NAME OF DEPENDENT	RELATIONSHIP <input type="checkbox"/> OTHER (EXPLAIN)	MARITAL STATUS (OTHER THAN SPOUSE)
	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	
IF CLAIM IS FOR DEPENDENT CHILD 19 OR OLDER, IS CHILD ENROLLED AS A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF SCHOOL	DATE OF BIRTH: MONTH/DAY/YEAR
AT TIME CHARGES WERE INCURRED (IF ANSWER TO EITHER IS YES, GIVE EMPLOYER'S NAME AND ADDRESS)		
WAS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF CLAIM WAS FOR CHILD, WAS CHILD EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

### COMPLETE FOR ALL PATIENTS

DIAGNOSIS OR NATURE OF INJURY	
WHEN WHERE YOU FIRST TREATED FOR THIS CONDITION? (MONTH, DAY, YEAR)	NAME AND ADDRESS OF PHYSICIAN WHO FIRST TREATED YOU
<b>IS PATIENT ALSO COVERED FOR BENEFITS BY:</b> a. Other Group Health Insurance of any kind including Blue Cross and Blue Shield? <input type="checkbox"/> YES <input type="checkbox"/> NO b. Group prepayment arrangement providing for medical care and treatment <input type="checkbox"/> YES <input type="checkbox"/> NO c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? <input type="checkbox"/> YES <input type="checkbox"/> NO d. No fault automobile insurance as a result of injuries sustained in an automobile accident? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>WAS ILLNESS OR INJURY DUE IN ANY WAY:</b> a. To the patient's occupation? <input type="checkbox"/> YES <input type="checkbox"/> NO b. To an automobile accident? <input type="checkbox"/> YES <input type="checkbox"/> NO c. To any other type of accident? <input type="checkbox"/> YES <input type="checkbox"/> NO
If any of the above answered YES please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or government agency.	
REMARKS	
ACCIDENT	
DATE (TIME: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.)	(PLACE OF ACCIDENT <input type="checkbox"/> WORK <input type="checkbox"/> OTHER)
HOW DID ACCIDENT HAPPEN?	NAME AND ADDRESS WHERE ACCIDENT OCCURRED
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Medical Benefits to Physician or supplier for services described within.	SIGNED (PATIENT, OR PARENT IF MINOR) DATE
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical information necessary to process this claim.	SIGNED (PATIENT, OR PARENT IF MINOR) DATE
EMPLOYEE SIGNATURE	PATIENT SIGNATURE (UNLESS MINOR) DATE

**STOP - If attaching an itemized statement, do not complete this side.**

*Itemized statements must show Physician's name and address, dates and types of services, charges, patient's name and diagnosis.*

PATIENT'S NAME (FIRST, MI/LAST)		PATIENT'S BIRTH DATE (MO/DAY/YR)		EMPLOYEE'S SOCIAL SECURITY NUMBER		
<b>VERIFICATION OF SERVICES</b>						
In order to process your bill for services as part of your patient's claim for health care expenses reimbursement, we require the following data. <b>Your cooperation is appreciated.</b>						
<b>PHYSICIAN OR SUPPLIER INFORMATION</b>						
DATE OF	←	ILLNESS (FIRST SYMPTOM), OR INJURY (ACCIDENT), OR PREGNANCY (LMP)	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
PROVIDER OF CARE (PLEASE CHECK)		IF OTHER THAN ATTENDING, GIVE NAME OF REFERRING PHYSICIAN				
<input type="checkbox"/> ATTENDING <input type="checkbox"/> SURGEON <input type="checkbox"/> CONSULTING						
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)			FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES			
			ADMITTED	DISCHARGED		
DIAGNOSIS PLEASE INDICATE ICD9-CM OR DSM III CODES						
PRIMARY			SECONDARY			
DATE OF SERVICE	PLACE OF SERVICE	CPT PROCEDURE (IDENTIFY)	Fully Describe procedures, types of therapy, or services furnished for each date given, indicate whether primary or secondary (if mental therapy indicate length of session)	CHARGES	AMT. PAID	BALANCE DUE
SIGNATURE OF PROVIDER				TOTAL CHARGE	AMOUNT PAID	BALANCE DUE
DATE	SIGNED	DEGREE				
YOUR PATIENT'S ACCOUNT NO.		PROVIDER I.D. NUMBER	PROVIDER'S NAME, ADDRESS, ZIP CODE, AND TELEPHONE NUMBER			
<i>If the services were rendered by a psychiatric worker, the following certification must be completed by the attending physician.</i>						
Therapy performed by _____						
was conducted at my direction and under my supervision and I have consulted with the Therapist regarding the patient within the last 90 days. Further, I have reviewed and approved the Plan of Treatment and have examined the patient on the date indicated below.						
NAME OF ATTENDING PHYSICIAN _____			DATE OF EXAMINATION _____			
ADDRESS OF ATTENDING PHYSICIAN _____			ATTENDING PHYSICIAN'S SIGNATURE _____			
			PROFESSIONAL STATUS _____			

- \* Place of service codes**
- |                            |                              |                                  |                                    |
|----------------------------|------------------------------|----------------------------------|------------------------------------|
| 1-(IH) Inpatient Hospital  | 4-(H) Patient's Home         | 7-(NH) Nursing Home              | 0-(OL) Other Location              |
| 2-(OH) Outpatient Hospital | 5- Daycare Facility (PSY)    | 8-(SNF) Skilled Nursing Facility | A-(IL) Independent Laboratory      |
| 3-(O) Doctor's Office      | 6- Night Care Facility (PSY) | 9- Ambulance                     | B- Other Medical Surgical Facility |