Yonkers Federation of Teachers Welfare Fund

35 EAST GRASSY SPRAIN ROAD
YONKERS, NEW YORK 10710
914-793-0393

STATEMENT OF CLAIM FOR PRESCRIPTION APPLIANCE BENEFIT

MEMBER MUST COMPLETE THIS SECTION

PATIENT'S NAME	RELATIONSHIP TO MEMBER ☐ Self ☐ Spouse ☐ Child ☐ Other	PATIENT'S BIRTHDATE
NAME OF MEMBER	SOCIAL SECURITY NUMBER	DATE OF BIRTH
HOME ADDRESS CITY STATE ZIP CODE		HOME PHONE
NAME OF SCHOOL OR BUILDING ASSIGNMENT	DATE OF EMPLOYMENT IN YONKERS SCHOOL SYSTEM	

ARE PRESCRIPTION APPLIANCE BENEFITS AVAILABLE FROM ANY OTHER PROVIDER FOR THIS PATIENT? ☐ YES ☐ NO

If YES, indicate the following and annex the original Explanation of Benefits from primary carrier, if applicable.

SPOUSE'S NAME: _____ SPOUSE'S SOCIAL SECURITY NUMBER: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S DATE OF BIRTH: _____

SPOUSE'S BENEFIT PLAN(S) NO. AND INSURER(S): _____

Check one of the following: I am enclosing a voucher from

Amount Claimed $ _____

___ My State Sponsored Health Plan

___ My HMO

___ Other

I certify that the foregoing information is true and correct. I understand I am financially responsible for any expense not covered by this benefit.

Date _____ Member's Signature _____

This form, when completed, is to be mailed WITH THE VOUCHER AND A COPY OF THE RECEIPT MARKED "PAID" STATING A COMPLETE DESCRIPTION OF THE APPLIANCE, DATE PURCHASED, NAME OF PERSON APPLIANCE WAS PURCHASED FOR AND AMOUNT PAID to: YONKERS FEDERATION OF TEACHERS WELFARE FUND, 35 EAST GRASSY SPRAIN ROAD, YONKERS, NEW YORK 10710 within 90 days of the receipt of your voucher from the State sponsored health plan.

Note: Prescription appliances include crutches, wheelchairs, artificial limbs, orthopedic appliances and other necessary medical equipment required for therapeutic use.

The voucher you submit with this application shows the amount of payment made to you or your dependent for the prescribed appliance. The Prescription Appliance Benefit provided by the Fund will reimburse you for the full deductible amount and the cost of the prescription appliance not covered by the State plan. Refer to the Benefits Booklet published by the Fund for a complete description of this benefit.

FOR ADMINISTRATOR ONLY

MEMBER / DEPENDENT	AMOUNT PAID $ _____	FOR YEAR _____