

PLAN ADMINISTERED BY

POMCO

Bedford Schools HEALTH PLAN

RETURN TO:

POMCO
P.O. BOX 6329
SYRACUSE, NY 13217
Tel : 1-800-234-9862

MEDICAL/SURGICAL/MAJOR MEDICAL BENEFIT REQUEST FORM

PATIENT INFORMATION SECTION

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F		4. PATIENTS DATE OF BIRTH MONTH DAY YEAR		
5. IF FULL TIME STUDENT GIVE NAME AND ADDRESS OF SCHOOL AND YEAR OF GRADUATION								
6. EMPLOYEE NAME FIRST MIDDLE LAST				7. EMPLOYEE SOCIAL SECURITY NUMBER				
8. EMPLOYEE MAILING ADDRESS				EMPLOYEE'S BIRTH DATE		9. EMPLOYER Bedford Schools Plan 940		
CITY, STATE, ZIP				10. IS TREATMENT A RESULT OF AN AUTO ACCIDENT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, GIVE DESCRIPTION AND DATE.				
11. IS THE TREATMENT A RESULT OF AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES PLEASE DESCRIBE. HOW, WHEN AND WHERE?						IS TREATMENT DUE TO A WORK-RELATED CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
12. IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO SPOUSE'S NAME			SPOUSE'S BIRTH DATE		SPOUSE'S SOCIAL SECURITY NUMBER			
13. NAME, ADDRESS AND PHONE NUMBER OF SPOUSE'S EMPLOYER								
14. IS THE PATIENT, YOUR SPOUSE, YOURSELF, OR ANY OTHER FAMILY MEMBER COVERED BY ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ANSWER QUESTION 15.						NAME OF FAMILY MEMBER COVERED		
15. HEALTH PLAN NAME			GROUP NUMBER			NAME AND ADDRESS OF OTHER HEALTH INSURANCE COMPANY		
16. I CERTIFY THE INFORMATION GIVEN BY ME IS COMPLETE AND CORRECT, AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE PATIENT NAMED. I AUTHORIZE ANY PHYSICIAN OR HOSPITAL TO PROVIDE PERTINENT RECORDS TO POMCO UPON REQUEST TO ESTABLISH MY CLAIM FOR BENEFITS UNDER THIS PLAN.								
SIGNATURE OF COVERED EMPLOYEE						DATE		
17. I AUTHORIZE POMCO TO PAY ANY BENEFITS DUE TO THE PROVIDER I HAVE INDICATED.								
SIGNED (EMPLOYEE)			DATE			PLEASE PAY DR.		

PHYSICIAN OR PROVIDER INFORMATION (SEE REVERSE FOR INSTRUCTIONS)

18. ONSET OF INJURY OR ILLNESS		19. DATE FIRST CONSULTED BY YOU FOR THIS CONDITION		20. IF EMERGENCY ILLNESS OR INJURY, BRIEFLY DESCRIBE.			
PLACE OF SERVICES CODES H - HOSPITAL O - OFFICE VISITS L - LAB OP - OUTPATIENT X - OTHER				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY			
DATE OF SERVICE	PLACE OF SERVICE CODE	DIAGNOSTIC CODE (ICD,DSM)	PROCEDURE CODE (CPT- 4)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		FEE	
PROVIDER NAME AND ADDRESS				TOTAL FEE CHARGED			
CITY, STATE, ZIP				AMOUNT PAID			
TAXPAYER IDENTIFICATION NUMBER				BALANCE DUE			

I HEREBY CERTIFY THAT THE PROCEDURES INDICATED BY DATE HAVE BEEN COMPLETED.

DOCTOR'S SIGNATURE _____ DATE _____
PHONE NUMBER _____

EMPLOYEE

PHYSICIAN

Bedford Schools HEALTH PLAN

HOW TO REQUEST BENEFITS

1. COMPLETE ITEMS 1 THROUGH 10 UNDER THE PATIENT INFORMATION SECTION. IF YOU ARE MARRIED, OR HAVE OTHER HEALTH BENEFITS, ITEMS 12,13,14, AND 15 MUST BE COMPLETED. IF ANY INFORMATION IS MISSING, IT WILL DELAY THE PAYMENT OF YOUR CLAIM.
2. HAVE YOUR DOCTOR COMPLETE THE PHYSICIAN'S INFORMATION SECTION, OR SUBMIT COMPLETELY ITEMIZED BILLS. AN ITEMIZED BILL MUST CONTAIN: PATIENT'S NAME, RELATIONSHIP, DATE OF SERVICE, TYPE OF SERVICE RENDERED, NATURE OF CONDITION BEING TREATED. IF THIS INFORMATION IS MISSING, YOU MAY WRITE IT ON THE BILL, AND SIGN YOUR NAME. IF YOU GO TO A NON-PARTICIPATING PHARMACY OR DO NOT USE YOUR PRESCRIPTION DRUG CARD, COMPLETE A SEPARATE PRESCRIPTION DRUG CLAIM FORM.
3. IF YOU WANT BENEFITS PAID TO YOUR DOCTOR, OR PROVIDER DIRECTLY, BE SURE TO SIGN ITEM 17.
4. COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER.
5. THE COMPLETED CLAIM FORM SHOULD BE RETURNED TO:

POMCO
P.O. BOX 6329
SYRACUSE, NY 13217

TOLL FREE NUMBER 1-800-234-9862

IMPORTANT REMINDER:
PLEASE BE SURE THE EMPLOYEE'S SOCIAL SECURITY NUMBER HAS BEEN PROVIDED.

POMCO®

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACTUAL MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME"