RETIREE AND PARA

EXCESS MEDICAL BENEFIT CLAIM FORM

MAIL CLAIMS TO:

Dickinson Group, LLC
585 Stewart Avenue, Suite 330
Garden City, NY 11530
Phone: (877) 347-7225
Fax: (516) 740-5417
E-mail: GNSC@DickinsonGrp.com

Patient's Name	Relationship to Member	Patient's Date of Birth	Patient's Social Security Number

Member's Last Name	Member's First name	Initial	Member's Social Security Number XXX-XX-___ ___ ___ ___ Member date of birth
Full Mailing Address No. and Street Apt. No. State and Zip Code			Has address changed Y or N Is this the first claim filed by you Y or N

Is your spouse employed? Y or N	If Yes, give name and address of your spouse's employer
Are benefits available from any other group insurance carrier for this patient? Y or N If YES, give name and carrier, plus name and ID No. of Subscriber:	Spouse date of birth: Month Day Year

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 AVALIABLE UNDER ANY OTHER GROUP PLAN EXCEPT AS INDICATED ABOVE.

MEMBER SIGNATURE _____ **DATE** _____

Mark the benefit (s) for which you are applying: PLEASE ATTACH the explanation of benefits from the Empire Plan (United Health Care-Blue Cross), or any other group coverage along with applicable receipts and supporting documents.

☐ **VISION CARE BENEFIT**
This benefit provides up to a maximum of $250 per insured person once every two policy years.

☐ **OUT-PATIENT PSYCHIATRIC BENEFIT***
This benefit will pay up to $25.00 per visit for out-of-network provider. Will reimburse co-payment up to $25.00 for in-network provider. This benefit pays up to $600 for or the participant and/or family with an additional 1% of costs incurred in that same year.

☐ **OUT-PATIENT REHABILITATION BENEFIT***
This benefit is provided on a first dollar basis and coordinated with the Empire Plan (United Health Care-Blue Cross) to $600 with an additional 1% of all out-patient rehabilitations costs.

☐ **IN-HOSPITAL CASH BENEFIT***
This benefit is provided for MEMBER and SPOUSE at $50/day, to a maximum of 7 day for in hospital only.

☐ **IN-HOSPITAL PRIVATE DUTY NURSING BENEFIT***
This benefit provides 50% of the Usual and Customary charge for the first 48 hours of private duty nursing/hospitalization.

☐ **OUT OF NETWORK – DEDUCTIBLE BENEFIT***
This benefit pays up to and including $400 of your annual Out-of-Network Deductible for the participant and/or family with an additional 1% of all deductible costs incurred in that same year.

****CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE DATE ON THE EMPIRE EXPLANATION OF BENEFTIS****