



# Management Benefits Fund

## SUPERIMPOSED MAJOR MEDICAL PLAN (SMMP) CLAIM FORM

SUBMISSION TYPE (Check one):  SMMP Claims  SMMP Adult Wellness Claims

<b>A. MEMBER INFORMATION</b>		SOCIAL SECURITY #	-	-	DATE OF BIRTH	/	/	/
<input type="checkbox"/> ACTIVE	<input type="checkbox"/> RETIRED	<input type="checkbox"/> COBRA	<input type="checkbox"/> SURVIVOR	<input type="checkbox"/> LTD	DISABLED DATE (if applicable)	/	/	/
LAST NAME			FIRST NAME			MI		
ADDRESS					WORK TELEPHONE # ( )		-	
CITY		STATE	ZIP		HOME TELEPHONE # ( )		-	
CITY HEALTH PLAN NAME:				TYPE OF PLAN: <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> EPO <input type="checkbox"/> HMO <input type="checkbox"/> OTHER				

PRESCRIPTION DRUG COVERAGE:  YES  NO **PLEASE ATTACH COPIES OF ALL HEALTH PLAN IDENTIFICATION CARDS**

IS THERE ANY OTHER COVERAGE?  NO  YES (IF YES, YOU MUST LIST ALL OTHER COVERAGES, INCLUDING MEDICARE COVERAGE)

	INSURED ID#	PLAN NAME AND PLAN NUMBER	PLAN EMPLOYER OR SPONSOR
MEMBER			
SPOUSE/DOMESTIC PARTNER			
SPOUSE/DOMESTIC PARTNER (ADDITIONAL COVERAGE, IF ANY)			
DEPENDENT			

<b>B. PATIENT INFORMATION</b>		SOCIAL SECURITY #	-	-	DATE OF BIRTH	/	/	/	
LAST NAME		IF OTHER THAN MEMBER			FIRST NAME		IF OTHER THAN MEMBER		MI
<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> EMPLOYED	<input type="checkbox"/> FULL-TIME STUDENT						
PATIENT RELATIONSHIP TO MBF MEMBER:				<input type="checkbox"/> SPOUSE/DOMESTIC PARTNER		<input type="checkbox"/> DEPENDENT			
PATIENT CONDITION IS RELATED TO: EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO									

**C. CLAIM INFORMATION** THIS SECTION MUST BE COMPLETED ONLY IF AN ITEMIZED STATEMENT FROM THE PROVIDER IS NOT PROVIDED.

DATES OF SERVICE FROM MM DD YY	TO MM DD YY	PLACE OF SERVICE	CPT/ HCPCS	PROCEDURES, SERVICES, OR SUPPLIES	MODIFIER	UNITS	DIAGNOSIS CODE	\$ CHARGES
								\$
								\$
								\$
								\$
								\$

FEDERAL TAX I.D. #: (SS#/EIN) \_\_\_\_\_ LICENSE #: \_\_\_\_\_ DEGREE: \_\_\_\_\_

TOTAL CHARGE \$ \_\_\_\_\_ AMOUNT PAID \$ \_\_\_\_\_ BALANCE DUE \$ \_\_\_\_\_

SIGNATURE OF PROVIDER: \_\_\_\_\_ DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

NAME, ADDRESS, AND PHONE NUMBER OF PROVIDER (Please Print)

**D. MEMBER/PATIENT'S SIGNATURE AND RELEASE** (Member must sign all claims. If not a minor, dependent patient must also sign.)

I hereby apply for benefits and certify that the above information is complete, true and correct. I authorize all physicians and other medical professionals, hospitals and other medical care institutions, and insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit plan administrators to provide ASO and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on ASO's behalf, with information concerning medical care, advice, treatment or supplies provided to the Patient, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photostatic copy of this authorization is as valid as the original. **Claim cannot be processed without member's signature.**

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_ Patient's Signature (If other than member, and if patient is not a minor) \_\_\_\_\_ Date \_\_\_\_\_

ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY FUND OR INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING FALSE, OR MISLEADING INFORMATION, MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE BY LAW.

Please refer to the SMMP section of the MBF Benefits Booklet available on MBF's Web site at [nyc.gov/html/olr](http://nyc.gov/html/olr) for a general list of covered expenses, exclusions, limitations, and maximums for both SMMP and Adult Wellness Benefit.

The Superimposed Major Medical Plan (**SMMP**) provides supplemental coverage for qualifying out-of-pocket medical expenses, which remain after all other health coverage allowances have been applied.

The **Adult Wellness Benefit** provides coverage for members and their spouse/domestic partner for periodic routine physicals and screening examinations to promote prevention, early detection, and early intervention of disease. In keeping with this philosophy, services covered under the Adult Wellness Benefit Program will not be subject to a deductible.

*Please note: If you have basic coverage for certain services through in-network providers only and/or if you must pre-certify services, you must comply with the provisions of your basic plan. If you do not, your coverage under the SMMP will be affected.*

**HOW CLAIMS SHOULD BE SUBMITTED:** Out-of-pocket covered medical expenses should be submitted as they are incurred.

*Please note: The SMMP claim form must be completely filled out and submitted with the necessary documentation. Failure to complete the claim form properly may result in the pending of the claim. Only actual remaining out-of-pocket expenses will be considered for payment. Proof of payment, or verification of remaining out-of-pocket expenses if proof of payment cannot be obtained, is required. Payment will be made to the member, NOT to the provider.*

1. Submit medical bills to your primary health plan for payment (or to apply charges toward a deductible or co-insurance).

*Please note: If you are a participant in the Health Benefits Buy-Out Waiver Program, you are covered for primary health benefits either under your spouse's/domestic partner's plan or through other employment. Medical expenses must first be submitted to the other plans for payment.*

2. If you are covered under both the City's Health Benefits Program and a spouse's/domestic partner's plan (or a plan through other employment), medical bills must be submitted to **both** plans before you submit the bill under the SMMP.

3. Compile all itemized bills generated from your health care provider related to claims.

- a) Your documents must include the diagnosis codes and CPT procedure codes. These codes must be identified with the procedure and other required information on the claim form in Section C-"Claim Information." If they are not included, your claim will be pended until this information is received.
- b) Outpatient mental health claims also require all of the information requested in Section C - "Claim Information" on the claim form. Incomplete statements of rendered services submitted on provider letterhead are not acceptable and will be pended until the required information is received (only for SMMP claims).
- c) **IF AN ITEMIZED STATEMENT FROM THE PROVIDER CONTAINING ALL THE INFORMATION REQUIRED IS ATTACHED, THEN IT IS NOT NECESSARY TO COMPLETE SECTION C.**

4. Compile the Explanation of Benefits (EOB) statements provided by all health plan(s) under which you have coverage in reference to the above itemized bills.

5. If you have prescription drug coverage through one or more of the health plan(s) under which you are covered, please include a copy of each drug card (only for SMMP claims).

6. Include proof of payment (i.e., receipts and cancelled checks) for out-of-pocket expenses.

7. Submit claim form and all documentation to:

**MBF SMMP CLAIMS**  
**Administrative Services Only (ASO), Inc.**  
P.O. Box 9009  
Lynbrook, NY 11563-9009  
Toll free: (877) 844-SMMP (7667)