

**UPSE Benefit Plan
Columbia County Participant Reimbursement Form**

**UNITED PUBLIC SERVICE
EMPLOYEE BENEFIT PLAN
3555 VETERANS HIGHWAY, SUITE H
RONKONKOMA, NY 11779
Telephone: 1.800.833.3688**

Use this form to Claim UPSE Benefit Fund benefits for

DOCTOR OFFICE VISITS

Claim Form must be completed and signed by the UPSE Employee Benefit Fund Participant. Attached a copy of any explanation of benefits and proof of payment along with this form. All required documentation must be attached. *Incomplete claims will be returned.*

MAIL COMPLETED CLAIMS TO:

United Public Service Employee Benefit Plan
3555 Veterans Highway, Suite H, Ronkonkoma, NY 11779

| | | | |
|--|-------------------------------------|---------------------|---|
| (Members Last Name) | (First) | (Initial) | (Social Security (last four#'s ONLY)) |
| (Number & Street) | (Apt. No.) | (Village/Town/City) | (St.) (Zip) |
| () | (Member's Daytime Phone Number) | (Member's Employer) | (Member's Signature) |
| (Member's Health Insurance carrier(s)) | (Spouse's Health Insurance carrier) | | |

The plan will reimburse participants and their eligible dependents that are covered under the UPSE Plan and one of the County Health Plans \$5.00 per visit up to 15 visits per year (\$75.00 annual maximum combined Individual and Family). This represents the difference that employees paid under the previous plan (\$20.00) and the current plan \$25.00.

In order to be reimbursed, you must forward a receipt documenting a \$25.00 office visit payment to a participating provider of your County Health Plan. The receipt must contain the doctor's name and address, together with the name of the participant/patient, and the amount paid by you or your eligible dependent. Claims are to be forwarded to the fund office along with this form in the beginning of January and July. Reimbursements will be made at the end of July and January for the prior six (6) months, (January 1 - June 30) and (July 1 - December 31).