HealthSmart | MEMBER BENEFITS nysut Working to Benefit You

CATASTROPHE MAJOR MEDICAL (CMM) CLAIM FORM INSTRUCTIONS

1. When to use this claim form?

This form is to be used for claim submission under the NYSUT Member Benefits CMM Insurance Trust-sponsored CMM Plan for policy numbers CMMI-003 (Voluntary) and CMMI-004 (Group). A completed claim form is required with the first claim submission each calendar year however, if any personal or insurance information changes, please submit updated information via a new claim form. HealthSmart reserves the right to request another completed claim form if necessary.

2. Who should use this form?

This form is for CMM Participant filing claims with benefit period effective dates of January 1, 2018 and beyond. If your benefit period effective date is prior to January 1, 2018, you must continue to submit your claims to Association Member Benefits Advisors (AMBA) until your benefit period ends.

3. What information is needed for claim submission?

1. An Explanation of Benefits (EOB) from all other insurance carriers you have;
2. An itemized statement from your service provider; and
3. Proof of payment for individual claims over $750.00

For **prescription drug claims**, you will need to include a pharmacy receipt and prescription details provided by the pharmacy.

When first initiating a home health care or nursing **home/convalescent care facility claim,** refer to the CMM Claim Reference Guide for further information. The Guide is available at healthsmart.com/nysut or by calling HealthSmart toll-free at 844-552-7805.

4. Do I need to sign the attached HIPAA Authorization form?

Yes. By signing this authorization, you will allow HealthSmart Benefit Solutions, the Administrator, to obtain additional information if necessary. Failure to provide the authorization may delay processing.

5. Where should I send my completed claim form and supporting documentation?

HealthSmart Benefit Solutions, Inc
PO Box 1014, Charleston, WV 25324-1014
Fax: 806-473-2535
Online claim filing is also available at healthsmart.com/nysut under "How to and Questions" & then "File a Claim."
IMPORTANT: Claims must be filed within two (2) years of incurring the claim expense. All submissionsafter that time will be declined.

6. What if I have questions?

Contact HealthSmart Benefit Solutions' customer service team at 844-552-7805 or visit healthsmart.com/nysut. You can also refer to the CMM Claim Reference Guide for further information, which is available by calling HealthSmart or downloading it at healthsmart.com/nysut.

IMPORTANT
Have you submitted claims to Association Member Benefits Advisors (AMBA) for an ongoing benefit period or in an attempt to reach a deductible?

☐ **YES** ☐ **NO**

If the answer is Yes, send your claims to Association Member Benefits Advisors (AMBA) at:
Association Member Benefits Advisors (AMBA)
PO Box 10362, Des Moines, IA 50306-0362
888-386-9788

PARTICIPANT/POLICY HOLDER & CLAIMANT INFORMATION

Name of Participant (first, middle initial, last) (Please Print)	Participant NYSUT ID #	Policy #(check one) ☐ CMMI-003 ☐ CMMI-004	
Participant's Address, Street & No.	City	State	Zip
Married ☐ Divorced ☐ Single ☐ Other ☐	Date of Birth	Home Phone	Daytime Phone
Claimant's Name (first, middle initial, last)		Claimant's relationship to Participant	
Claimant's Address, Street & No ☐ Same as Participant	City	State	Zip
Claimant's Date of Birth	Married ☐ Single ☐	Is Claimant employed? Yes ☐ No ☐	
Is the Claimant eligible for coverage under an employer-sponsored health plan? Yes ☐ No ☐			
Is the Claimant's condition related to: ☐ Employment? (Current or Previous) ☐ Auto Accident? ☐ Other Accident? ☐ None			
Is the Claimant involved in any pending litigation due to the condition? Yes ☐ No ☐			

Claimant's other insurance: Please indicate the Claimant's other health insurance coverage(s) by checking "yes" and providing the policy number if the Claimant has coverage under any of the following plans.

Plan	Yes	Policy #
AARP	Yes ☐	Policy #
BlueCross	Yes ☐	Policy #
GHI	Yes ☐	Policy #
Emblem	Yes ☐	Policy #
Medicaid	Yes ☐	Policy #
Medicare	Yes ☐	Policy #
S.H.I.P.	Yes ☐	Policy # N/A - S.H.I.P does not issue a Policy #
United Healthcare	Yes ☐	Policy #

Please list all other coverages the patient has **including prescription drug and long-term care policies**. Failure to disclose **all** policies may result in inaccurate benefits being paid and/or require that benefits paid be returned to the Plan. If space is not adequate, use a separate page.

Insurance Company Name ______________________________

Address ______________________________

Policy # ______________________________

Insurance Company Name ______________________________

Address ______________________________

Policy # ______________________________

CLAIM INFORMATION

You may be submitting claims for which you are satisfying your annual out-of-pocket deductible, seeking reimbursement or attempting to satisfy home health care or convalescent care waiting periods. For each claim submitted you must provide an EOB, itemized statement and proof of payment for individual claims over $750, as applicable. Documentation in addition to these items may be required and will be determined on a case-by-case basis.

IMPORTANT NOTICE: It is unlawful for any person to knowingly, and with intent to defraud, present or cause to be presented, or prepare with the knowledge and belief that it will be presented to a self-insurer, a claim for payment, containing any materially false information concerning any material fact related to such claim, or to conceal, for the purpose of misleading, information concerning any material fact related to such claim (collectively, "Unlawful Acts"). Such Unlawful Acts may also lead to a denial of benefits from this Plan.

______________________________ Claimant Signature

______________________________ Date

Mail or Fax this completed form along with claims and any documentation (if applicable) to:

HealthSmart Benefit Solutions
PO BOX 1014
Charleston, WV 25324-1014
Fax- 806-473-2535

For questions call HealthSmart at:
844-552-7805

Online claim filing is also available at healthsmart.com/nysut.

DON'T FORGET

- Sign and date the claim form.
- Submit this form with a copy of the documents needed for your claim and proof of payment for individual claims over $750.00.
- A completed claim form is required with the first claim submission each calendar year and when any personal or insurance information changes (note: If submitting without a claim form please include the Participant's full name, Group number (5959) and Group Name (NYSUT) on your claim and/or documentation submitted).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Claimant's Name	Date of Birth	Participant's NYSUT ID #

I hereby authorize all of the people and organizations listed below to give NYSUT Member Benefits Catastrophe Major Medical Insurance Trust ("Trust"), and their authorized representatives, including its administrator, HealthSmart Benefit Solutions, Inc., as well as other agents and insurance support organizations, (collectively, the "Recipients"), the following information:

- Any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- Any physician or medical practitioner;
- Any hospital, clinic or other health care facility;
- Any insurance or reinsurance company;
- Any consumer reporting agency or insurance support organization;
- Any consumer reporting agency or insurance support organization;
- The Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipients to:

- Determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- Detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Recipients listed above are subject to federal privacy regulations. I understand that information released to the Recipients will be used and disclosed as described in the Trust's HIPAA Privacy Notice, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or if other law allows the Recipients to contest a claim under the policy or to contest the policy itself, by sending a written request to: HealthSmart Benefit Solutions, Inc., PO Box 1014, Charleston, WV 25324-1014. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipients for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Recipients may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

______________________________ Signature of Claimant and Claimant's Personal Representative

______________________________ Date

______________________________ Description of Authority of Personal Representative (if applicable)