Welfare Fund

Brewster Teachers Association
Welfare Fund ***Multi-Claim Form***

c/o Preferred Group Plans, Inc.
P.O. Box 15136
Albany. NY 12212-5136
(800) 573-7474 Fax: (518) 641-0325

Patient Name	M ☐ F ☐	Patient Soc. Sec # ___ - ___ - ___	Patient DOB
Relationship to Member: Self ☐ Spouse ☐ Child ☐ Other ☐		Work Phone ( )	
Member Name Last First Middle Initial		Member Soc. Sec. #	
Address	City State Zip	Home Phone ( )	

I certify that the information provided is correct and authorize the release of any information necessary to process this claim. Benefits are not available from any other source except as indicated above.

Member Signature ______________________ Date ____________

Please coordinate benefits with ______________________ Soc. Sec. # ____ - ____ - ____
(this applies to individuals who have a spouse working within the district)

Check all that apply and attach receipts:	**$ Amount**
❒ OPTICAL - Member/Dependents - $200 Per person **every other** school year 9/1-8/31	
❒ PROSTHETIC DEVICE - Member/Dependents - Balance paid in full after EOB.	
❒ AUDIO EXAM/HEARING AID - Member/Dependents - $200 per person **every other** calendar year	
❒ MEDICAL SUPPLEMENTAL FLEX - $250 per family per calendar year (****see below for elig. expenses for $250 total)**	
** INSURANCE DEDUCTIBLE	
** PHYSICAL EXAM	
** PSYCHIATRIC/FAMILY COUNSELING	
** MAMMOGRAPHY	
** CO-INSURANCE	
** MATERNITY	
** PRESCRIPTION DRUGS	
Total	

See the reverse of this form for additional instructions in filing claims.

MULTIPLE CLAIMS MAY BE SUBMITTED USING THIS FORM. CAREFULLY ARRANGE RECEIPTS AND INCLUDE ALL EOBS. ENCLOSE COPIES, NOT ORIGINALS. CHECK THE APPROPRIATE BOX TO THE LEFT OF EACH BENEFIT CATEGORY FOR EACH CLAIM.

CLAIMS MAY BE SUBMITTED TO PREFERRED GROUP PLANS, VIA FAX. MAKE SURE ALL CLAIM FORM COPIES AND ATTACHMENTS ARE LEGIBLE OR PAYMENT WILL BE DELAYED.

DO NOT SUBMIT DENTAL OR ORTODONTIA CLAIMS USING THIS FORM. ALL DENTAL CLAIMS MUST BE FILED ON A SEPARATE DENTAL FORM.

GOOD RECORDKEEPING WILL ENABLE MEMBERS TO TAKE FULL ADVANTAGE OF BTAWF BENEFITS.

ANY QUESTIONS REGARDING SUBMISSION OF CLAIMS MAY BE DIRECTED TO ANY TRUSTEE OR TO PREFERRED GROUP PLANS, DIRECTLY.

IF YOU EXPERIENCE A PROBLEM WITH THE PROCESSING OF A CLAIM, FIRST CONTACT PREFERRED GROUP PLANS, BEFORE CONTACTING A TRUSTEE OF THE FUND.

MEMBERS HAVE A RIGHT TO APPEAL THE DENIAL OF A CLAIM BY PREFERRED GROUP PLANS, BEFORE MAKING AN APPEAL, MEMBERS MUST CONTACT PREFERRED GROUP PLANS AND ATTEMPT TO RESOLVE THE ISSUE WITH PREFERRED GROUP PLANS. PLEASE CHECK THE BENEFIT BOOK FOR CLAIMS APPEAL INFORMATION.

ALL CLAIMS BY MEMBERS ARE STRICTLY CONFIDENTIAL. TRUSTEES OF THE BTAWF DO NOT REVIEW MEMBERS CLAIMS OR EOBS AND ARE NOT PRIVY TO ANY MEMBER'S USAGE OF FUND BENEFITS. APPEALS ARE LIKEWISE KEPT CONFIDENTIAL. THE TRUSTEES GRANT OR REJECT APPEALS BASED ON FACTS PRESENTED BY THE MEMBER IN WRITING TO PREFERRED GROUP PLANS. THE MEMBER MAKING AN APPEAL WILL NOT BE MADE KNOWN TO THE TRUSTEES.