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 and CMMI-004.

2. Who should use this form?

This form is for participants 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 Mercer Consumer 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 **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 any additional information needed to complete the processing of your claim. 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

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 Mercer Consumer for an ongoing benefit period or in an attempt to reach a deductible?

(✔) YES ( ) NO

If the answer is Yes, send your claims to Mercer Consumer at:

Mercer Consumer:
PO Box 10362
Des Moines, IA 50306-0362
888-386-9788

HealthSmart

MEMBER BENEFITS nysut Working to Benefit You

PARTICIPANT & PATIENT INFORMATION SECTION

Name of Participant (first, middle initial, last) (Please Print)			NYSUT ID #	Policy #(check one) ☐ CMMI-003 ☐ CMMI-004	
Participant's Address, Street & No.			City	State	Zip
Married ☐ Divorced ☐ Single ☐ Other ☐	Date of Birth	Male ☐ Female ☐	Home Phone	Daytime Phone	
Patient's Name for whom claim is being made (first, middle initial, last)				Patient's relationship to Participant	
Patient's Address, Street & No ☐ Same as Participant			City	State	Zip
Patient's Gender Male ☐ Female ☐	Patient's Date of Birth	Married ☐ Single ☐	Is Patient employed? Yes ☐ No ☐		
Is the patient eligible for coverage under an employer-sponsored health plan? Yes ☐ No ☐					
Diagnosis or nature of illness or injury					
If related to an injury, how, when and where did the injury occur?					

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

AARP	Yes ☐	Policy #
BlueCross	Yes ☐	Policy #
GHI	Yes ☐	Policy #
Medicaid	Yes ☐	Policy #
Medicare	Yes ☐	Policy #
S.H.I.P.	Yes ☐	Policy #
United Healthcare	Yes ☐	Policy #

Please list all other coverages the patient may have, including any long-term care policy information.
If space is not adequate, use separate page.

Insurance Co. Name _____

Address _____

Policy # _____

Insurance Co. Name _____

Address _____

Policy # _____

CLAIM INFORMATION

Claims must be submitted within two (2) years of incurring the claim expense.

You may be submitting claims for which you are satisfying your annual deductible and/or for which you are seeking reimbursement. For each claim submitted, complete the information below, as well as provide an EOB, itemized statement and proof of payment, as applicable.

If you have more claims than will fit on this form, please submit as many forms as needed or submit on a separate sheet of paper.

Claim	Date of Service	Provider Name	Type	Expected Reimbursement Amount
1			☐ Medical ☐ Drug ☐ Home Health Care ☐ Nursing/Conv Care ☐ Other	$
2			☐ Medical ☐ Drug ☐ Home Health Care ☐ Nursing/Conv Care ☐ Other	$
3			☐ Medical ☐ Drug ☐ Home Health Care ☐ Nursing/Conv Care ☐ Other	$
4			☐ Medical ☐ Drug ☐ Home Health Care ☐ Nursing/Conv Care ☐ Other	$
		Total Expected Reimbursement Amount		$

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's signature

_____ Date

Mail or Fax claims along with your documentation to:

Healthsmart Benefit Solutions:
PO Box 1014
Charleston, WV 25324-1014
Fax- 806-473-2535

For questions call HealthSmart at:
844-552-7805

Note - Submitting your claims to the incorrect Administrator may result in a denied claim that may need to be resubmitted to Mercer Consumer.

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

Patient's Name	Date of Birth	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;
- My employer, group policy holder, or benefit plan administrator; and
- 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 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 or Claimant's Personal Representative

Date

Description of Authority of Personal Representative (if applicable)