DOCTORS COUNCIL BENEFIT PLAN

50 Broadway, 11th Floor, Suite 1101, New York, New York 10004 (212) 532-7690 Fax (212) 481-4137

☐ CURRENTLY EMPLOYED ☐ SELF-PAY COBRA

THIS COMPLETED FORM MUST BE POSTMARKED, IF MAILED, OR RECEIVED WITHIN ONE (1) YEAR FROM THE DATE OF SERVICE, ALONG WITH YOUR RECEIPT FOR SERVICE(S) RENDERED AND IF APPLICABLE, STATEMENTS FROM OTHER INSURANCE CARRIERS.

RETURN TO:
Doctors Council Benefit Plan
50 Broadway, 11th Floor, Suite 1101
New York, New York 10004
Phone: 212 532-7690 • Fax: 212 481-4137
Email: benefits@doctorscouncil.org

MEMBER INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #

ADDRESS *Street* *City* *State* *Zip code*

HOME PHONE	HOME FAX	WORK PHONE	WORK FAX	CELL PHONE	WORK SITE

HOME EMAIL	WORK EMAIL

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	RELATIONSHIP TO MEMBER

IS PATIENT COVERED BY ANOTHER INSURANCE PLAN? ☐ YES ☐ NO

NAME AND ADDRESS OF OTHER INSURER:

NAME AND ADDRESS OF OTHER INSURER:

NAME AND ADDRESS OF OTHER INSURER:

BENEFIT YOU ARE APPLYING FOR: (CHECK ONE BOX ONLY)

☐ CHIROPRACTIC BENEFIT ☐ OPTICAL BENEFIT

☐ HOSPITAL INDEMNITY BENEFIT ☐ HEARING BENEFIT (*M.D. To Certify Below*)

PROVIDER INFORMATION : PROVIDER MUST COMPLETE THIS SECTION

NAME	ADDRESS	TELEPHONE NUMBER

DATE(S) OF SERVICE	DIAGNOSIS: (Hearing Benefit Only)	TREATMENT: For the Hearing Benefit indicate which ear(s) are affected.

PROVIDER'S SIGNATURE DATE	PROFESSIONAL DEGREE:	LICENSE NUMBER

MEMBER'S SIGNATURE DATE