

DOCTORS COUNCIL RETIREE WELFARE FUND50 Broadway, 11th Floor, Suite 1101, New York, New York 10004 (212) 532-7690 Fax (212) 481-4137

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 Retiree Welfare Fund
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 <i>Street</i>					<i>City</i>		<i>State Zip code</i>
HOME PHONE	HOME FAX	CELL PHONE	EMAIL				

PATIENT INFORMATION

LAST NAME		FIRST NAME		MI	BIRTHDATE	RELATIONSHIP TO MEMBER
IS PATIENT COVERED BY ANOTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> 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)

<input type="checkbox"/> HEARING BENEFIT (<i>M.D. To Certify Below</i>)	<input type="checkbox"/> PODIATRY BENEFIT
<input type="checkbox"/> PSYCHIATRIC BENEFIT	<input type="checkbox"/> PRIVATE DUTY NURSING – IN HOSPITAL

PROVIDER INFORMATION : PROVIDER MUST COMPLETE THIS SECTION

NAME		ADDRESS		TELEPHONE NUMBER
DATE(S) OF SERVICE	DIAGNOSIS/DSM IV:	TREATMENT: For the Hearing Benefit indicate which ear(s) are affected.		
MENTAL HEALTH PROVIDER MUST COMPLETE THE FOLLOWING: <input type="checkbox"/> BOARD CERTIFIED PSYCHIATRIST <input type="checkbox"/> BOARD ELIGIBLE PSYCHIATRIST				
<input type="checkbox"/> STATE LICENSED PSYCHOLOGIST		<input type="checkbox"/> LICENSED CLINICAL SOCIAL WORKER (LCSW)		
LENGTH OF EACH VISIT	CHARGE PER VISIT \$	TYPE OF VISIT: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP		
PROVIDER'S SIGNATURE		DATE	PROFESSIONAL DEGREE:	LICENSE NUMBER

MEMBER'S SIGNATURE

DATE

Office use only: Payment \$ _____ Approved By _____