

# PSPRS **Cancer Insurance Program**

MAIL CLAIM TO:  
 CANCER INSURANCE PROGRAM  
 P.O. BOX 17323  
 PHOENIX, AZ 85011-0323  
 FAX CLAIM TO:  
 602-296-2371

## ADDITIONAL BENEFITS CLAIM FORM\*\* PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

MEMBER INFORMATION					
MEMBER/CLAIMANT NAME:			SOCIAL SECURITY NUMBER		
STREET ADDRESS		CITY	STATE	ZIP	TELEPHONE (DAYTIME)
<b>**THIS FORM IS TO BE USED AFTER THE INITIAL CLAIM FORM HAS BEEN FILED, IF YOU HAVE NOT PREVIOUSLY SUBMITTED THE INITIAL CLAIM FORM ALONG WITH THE ATTENDING PHYSICIANS STATEMENT AND PAHTOLOGY REPORT, DO NOT USE THIS FORM.</b>					
CLAIM INFORMATION					
TYPE OF BILLING: (Circle one*)					
DOCTOR:	LAB:	HOSPITAL:	CLINIC:	TRANSPORTATION:	OTHER:
NAME OF BILLING PARTY: _____  BILLING ADDRESS: _____  CONTACT PHONE NUMBER: _____					
*Submit a separate form for each claim.					
DATE OF SERVICE			OUT OF POCKET AMOUNT		
REQUIRED DOCUMENTS					
PLEASE CHECK THE TYPES OF DOCUMENTS YOU HAVE ATTACHED COPIES OF:					
<input type="checkbox"/> BILLS FROM THE PROVIDER		<input type="checkbox"/> EXPLANATION OF BENEFITS FROM INSURANCE (EOB)**			
<input type="checkbox"/> PHARMACY PRINTOUTS		<input type="checkbox"/> CREDIT CARD RECEIPTS			
**MUST BE INCLUDED.					
AUTHORIZATION					
I authorize my doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, consumer reporting agency, employer, Social Security Administration or any other organization or person having any knowledge of the patient, employee or deceased, including financial institutions, to give Public Safety Personnel Retirement System or its authorized representative any information needed to determine policy claim benefits. This may include (but is not limited to) information regarding HIV antibody testing, Acquired Immune Deficiency Syndrome or related complexes, driving records, financial records, police or accident reports, mental illness and use of alcohol or drugs. A photocopy of this form is as valid as the original. This form will be in force for one year from the date shown below. I may revoke it at any time for information not then obtained by writing to Public Safety Personnel Retirement System. I certify that the foregoing statements and answers on this form are complete and true to the best of my knowledge.					
SIGNATURE OF MEMBER/CLAIMANT				DATE	