PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM

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SUPPLEMENTAL/PHARMACY BENEFITS CLAIM FORM

(This form is ONLY used after an Initial Claim Form has been filed and is for seeking payments from Schedule of Benefits other than diagnosis benefits.)

MEMBER/CLAIMANT INFORMATION		
PRINT NAME		**SSN**
ADDRESS	**CITY, STATE, ZIP**	**PHONE**

CLAIM INFORMATION (Select all that apply)					
☐	Radiology and Chemotherapy	☐	Cancer Intensive Care (ICU)	☐	Hospital Confinement
☐	Experimental	☐	Hospice Care, in home	☐	Hospice Care in Facility
☐	Pharmacy				

PROVIDER INFORMATION			
NAME OF PROVIDER	**ADDRESS /LOCATION** (INCLUDING CITY, STATE, ZIP)	**DATE OF SERVICE** (MM/DD/YYYY)	**OUT OF POCKET AMOUNT**

PHARMACY INFORMATION	
NAME OF PHARMACY	**ADDRESS /LOCATION** (INCLUDING CITY, STATE, ZIP)

SUPPLEMENTAL REQUIRED DOCUMENTS — We recommend that BOTH items below be included.

The service provided (chemotherapy, radiology, radiation, etc.) MUST be CLEARLY stated, or your claim may be denied. If denied for this reason, you may need to request a UB-04, or Statement from the provider. If your explanation of benefits (EOB) has sufficient information, we may accept this document without a billing from your provider

☐	Bill from Healthcare Provider	☐	Explanation of benefits (EOB) from Insurance Provider

PHARMACY REQUIRED DOCUMENTS	
☐	Pharmacy Printouts

AUTHORIZATION

l authorize my doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, consumer reporting agency, employer, Social Security Administration, pharmacy 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.

REQUIRED Signature of Member	**DATE** (MM/DD/YYYY)