Specialist Co-Payment Reimbursement Claim Form

Suffolk County Municipal Employees Benefit Fund
30 Orville Drive, Suite D-1
Bohemia, New York 11716-2513
(631) 319-4099 www.scmebf.org

FOR ADMINISTRATIVE USE ONLY

MEMBER: LAST FIRST	MEMBER ID (BF#) BF00
MAILING ADDRESS	DEPARTMENT
CITY STATE ZIP	OFFICE PHONE / HOME PHONE
EMAIL ADDRESS	CELL PHONE

Please call Empire Blue Cross Blue Shield at 1-800-939-7515 & request the previous year end printouts of all your specialist visits in PDF form. Please be aware that we cannot accept the spreadsheet version as these can be doctored.

You may also request a printout of all specialist visits by going to www.empireblue.com/login, logging in and click on Support & Live Chat.

Individual receipts will NOT be accepted as proof of payment!

This form is to be used for claiming the Specialist Co-Payment Reimbursement Benefit provided to eligible active Suffolk County Municipal Employees Benefit Fund members and their eligible dependents for specialist visits.

For a specialist visit with a co-pay of $50 the allowable co-pay reimbursement is $20, with no maximum each calendar year. For a specialist visit with a co-pay over $50 please attach an explanation of benefits from your health plan. **Excluded are Urgent Care, Emergency Room Visits, Laboratory Visits, Out of Network Providers, Physical Therapy, MRI, Radiology, Acupuncture, Chiropractor & Surgical Procedures. You must be a member of EMHP to receive this benefit. All rules and regulations governing the "health plan" apply to your Fund coverage.**

Claims for specialist co-payments can only be filed **ONCE** annually. **Submit ONLY after you have accumulated all your co-payment costs for the entire year. Additional reimbursement requested by a member who previously filed a claim, which was previously processed and paid, will be rejected!**

This claim form along with the necessary documentation **can be submitted starting June 1st** for specialist copays accumulated for the previous calendar year and must be submitted by May 31st of the following year (For example, you may **submit your claims after June 1, 2025 for your 2024 specialist co-pays and the claim must be received by the Fund office no later than May 31, 2026**).

Patient Name	Relation	Patient Name	Relation

Do You Get Reimbursed by An Alternate Insurance Plan? ☐ **Yes** ☐ **No**

If Yes, List Alternate Insurer: _____ **Attach Statement from Alternate Insurance**

Member MUST Enter the Amount of Co-Payments Reimbursed by Any Other Plan!

I certify the above charges were for the benefit of my eligible family members and I/we have not been reimbursed for these expenses from any other source. I authorize the release of any information pertaining to these specialist visits to the Benefit Fund or their representatives for the purpose of verification. **I FURTHER CERTIFY I HAVE SUBMITTED ALL EXPENSES FOR REIMBURSEMENT FOR THE YEAR FILED AND WAIVE THE RIGHT TO ANY ADDITIONAL BENEFIT!**

MEMBER SIGNATURE **DATE**

For Administrative Use Only

SPECIALIST CO-PAYMENT REIMBURSEMENT CLAIM FORM INSTRUCTIONS

Filing is limited to one (1) claim per family, per calendar year.

PLEASE READ CAREFULLY BEFORE COMPLETING THIS CLAIM FORM.

PRINTOUT FILINGS:

Specialist visits are for an active member, spouse or eligible domestic partner and covered children (see definitions below). Identify each family member and submit all printouts for each person. Please complete all required areas of information and **sign and date the bottom of the form**.

WHO IS ELIGIBLE:

Active member, spouse, duly enrolled domestic partner, unmarried dependent children to age 26 or dependent children incapable of self-sustaining employment by reason of mental or physical disability acquired before the termination of eligibility (prior to the age of twenty-six {26}and reside with and wholly depend upon the covered member for support.) The member must be enrolled in EMHP to receive this benefit.

EXCLUSIONS:

- Urgent Care
- Emergency Room Visits
- Laboratory Visits
- Out of Network Providers
- Physical Therapy
- MRI
- Radiology
- Acupuncture
- Chiropractor
- Surgical Procedure

INDIVIDUAL RECEIPTS:

Individual receipts will NOT be accepted as proof of payment!

HEALTH CARE PLAN PRINTOUT:

Complete all required areas of information, sign, and date the form and attach a printout from your health plan coverage.

For a specialist visit with a co-pay over $50 please attach an explanation of benefits from your health plan.