

MULTI-BENEFITS CLAIM FORM

FOR OFFICE USE ONLY

NOV
CODE

**Social Service
Employees Union
Local 371**



AFSCME - AFL-CIO

WELFARE FUND

817 BROADWAY - NEW YORK, N.Y. 10003 - TEL: (212) 777-9000

DO NOT USE THIS FORM FOR ANY OTHER BENEFITS

CHECK ONLY ONE

SAT COURSE HEARING AID ABORTION BENEFIT PROSTHETIC APPLIANCE

PATIENT LAST NAME		PATIENT FIRST NAME		RELATIONSHIP TO MEMBER	DATE OF BIRTH
MEMBER LAST NAME		MEMBER FIRST NAME		SOCIAL SECURITY #	HOME PHONE ()
HOME ADDRESS				APT. #	MEMBER MAIDEN NAME
NUMBER	STREET	CITY	STATE	ZIP	
PAYROLL TITLE		DEPARTMENT	WORK LOCATION		OFFICE PHONE ()
MEMBER'S SIGNATURE					

ATTACH ALL BILLS: CASH REGISTER RECEIPTS AND CANCELLED CHECKS CANNOT BE PROCESSED.
ALL CLAIMS ARE SUBJECT TO AUDIT AND VERIFICATION

TO BE COMPLETED BY PROVIDER OF SERVICES WITH STAMP IMPRINT AND SIGNATURE (OR ATTACH BILLS OR RECEIPTS)

DATE OF SERVICE _____ PATIENT NAME _____

DESCRIBE SERVICES RENDERED _____

MATERIALS PROVIDED _____

NOTICE: SSEU LOCAL 371 MAKES PAYMENTS TO MEMBERS ONLY

DOCTOR OR
PROVIDER
STAMP
IMPRINT HERE



TOTAL FEE _____

PHONE _____

TAX ID NUMBER _____

PROVIDER'S SIGNATURE

ELIGIBILITY CHK