ANY QUESTIONS, PLEASE CONTACT FAZEENA DEEN @ 212 962-6061 EXT. 2332

CSA RETIREE WELFARE FUND HOME HEALTH AIDE CARE CLAIM FORM

BENEFIT LIMITATIONS

THE PURPOSE OF THIS BENEFIT IS TO PROVIDE NECESSARY CARE FOR MEMBERS AND/OR ELIGIBLE DEPENDENTS WHO BECOME INCAPACITATED AS A RESULT OF INJURY OR ILLNESS AND AS A RESULT OF THAT INJURY OR ILLNESS CANOT PERFORM AT LEAST two (2) ACTIVITIES OF DALY LIVING WITHOUT ASSISTANCE AS CERTIFIED BYTHE PATIENTS PRIMARY CARE PHYSICIAN. SUCH SERVICES MUST BE PROVIDED BY A CERTIFIED HEALTH AIDE OR A LICENSED HOME CARE AGENCY

THE ACTIVITIES OF DAILY LIVING ARE EATING, BATHING. BLADDER CONTROL. TOILETING, DRESSING, AND TRANSFERRING. IN ADDITION, ELIGIBILITY MAY ALSO COGNITIVE IMPAIRMENT DUE TO SUDDEN INJURY OR STROKE.

BENEFITS WILL BE PAID AT OF REASONABLE ANO CUSTOMARY CHARGES AFTER MEETING AN ANNUAL $100 HOME HEALTH AIDE DEDUCTIBLE* TO A CALENDAR YEAR MAXIMUM OF $10,000 INCREA5ED FROM $8,000 EFFECTIVE 1/1/19) AND LIFETIME MAXIMUM OF $30,000. THE DETERMINATION OF ELIGIBILITY AND REASONABLE AND CUSTOMARY CHARGES WILL BE AT THE SOLE DISCRETION OF THE TRUSTEES OF THE CSA RETIREE WELFARE FUND.

HOW TO FILE A CLAIM

1. PLEASE SIGN AND COMPLETE ALL PORTIONS OF THE ENCLOSED GREEN CLAIM FORM.
2. ATTACH COPIES OF ITEMIZED BILL, INCLUDING DATES AND TIME OF HOME HEALTH AIDE'S SERVICE AND COPIES OF CANCELLED CHECKS CORRESPONDING TO SUBMITTED SERVICE DATES. IF AN AGENCY BEING USED, THEIR INVOICE SHOULD INCLUDE ALL OF THE ABOVE.
3. A COPY OF THE HOME HEALTH AIDE'S CERTIFICATION MUST BE ATTACHED FOR EACH HOME HEALTH AIDE PROVIDING CARE OR VERIFICATION OF CERTIFICATION AND TRAINING BY A LICENSED AGENCY.

HOME HEALTH AIDE BENEFIT
PROVIDER SERVICE RECORD
(TO BE SUBMITTED WITH COPIES OF PROOF OF PAYMENT)

_____

DATE SUBMITTED

MEMBER: _____ S.S.# _____

PATIENT: _____ RELATION: _____

DATE OF SERVICE	TIME OF SERVICE START / END	TOTAL HRS SERVED	CHARGES PAID FOR SERVICE	PROVIDER NAME	CERTIFICATE NUMBER