CSA RETIREE WELFARE FUND
40 RECTOR STREET, 12TH FLOOR, NEW YORK, NY 10006
TEL: (212) 962-6061 FAX: (212) 964-4357

HOME HEALTH AIDE CLAIM FORM

PART I: MEMBER INFORMATION

MEMBER NAME ____ SOCIAL SECURITY # _____-______-_____
(LAST, FIRST, MIDDLE INITIAL)

ADDRESS ____ TELEPHONE # (_____) ______-_________

____

PART II: PATIENT INFORMATION

PATIENTS WHO ARE HOSPITALIZED OR RESIDING IN A NURSING HOME / REHABILTATION CENTER ARE ELIGIBLE FOR THIS BENEFIT

NAME OF PATIENT ____ DATE OF BIRTH _____-______-_____
(IF NOT MEMBER) (LAST, FIRST, MIDDLE INITIAL)

ADDRESS ____ TELEPHONE # (_____) ______-_________

____

CURRENT PATIENT RESIDENCE

☐ OWN RESIDENCE

☐ RESIDENTIAL / ASSISTED LIVING / PERSONAL CARE FACILITY

☐ OTHER: ____
(EXPLAINATION)

PART III: FACILITY INFORMATION

IF CURRENT RESIDENCE IS A NOT THE PATIENTS OWN COMPLETE THIS SECTION

NAME OF FACILITY ____

ADDRESS ____ TELEPHONE # (_____) ______-_________

____

DATE OF ENTRY _____-______-_____

PART IV: INDIVIDUAL COMPLETING THIS FORM (IF DIFFERENT FROM MEMBER/PATIENT/CLAIMANT)

NAME ____
(LAST, FIRST, MIDDLE INITIAL)

RELATIONSHIP TO CLAIMANT ____

ADDRESS ____ TELEPHONE # (_____) ______-_________

____

PART V: PHYSICIAN INFORMATION

PLEASE LIST THE PATIENT'S PRIMARY PHYSICIAN THAT HAS BEEN CONSULTED IN REGARD TO THIS CONDITION

NAME ____

SPECIALTY ____

LAST DATE SEEN _____-______-_____

ADDRESS ____ TELEPHONE # (_____) ______-_________

____

PART VI: TO BE COMPLETED BY PHYSICIAN

WHAT IS THE PATIENT'S PRIMARY DIAGNOSIS? ____

____

OTHER CONTRIBUTING CONDITIONS: ____

____

WHAT ASSISTANCE DOES PATIENT NEED AND WHY? ____

____

____

WHEN DID THE PATIENT FIRST BEGIN TO NEED ASSISTANCE? _______________________________________

____

WHO PROVIDED THIS ASSISTANCE? ____

____

HOW LONG DO YOU ANTICIPATE PATIENT WILL NEED THIS ASSISTANCE? ________________________________

____

PHYSICIAN SIGNATURE ____

PRINT PHYSICIAN NAME ____ DATE _____-______-_____

PART VII: SIGNATURES

IF SOMEONE OTHER THAN THE CLAIMANT SIGNS THIS FORM, PLEASE ENCLOSE A COPY OF ANY POWER OF ATTORNEY, GUARDIANSHIP OR TRUST PAPERS

AUTHORIZATION FOR RELEASE OF INFORMATION: THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN, MEDICAL PRACTITIONER, CLINIC, OTHER MEDICAL FACILITY, PHARMACY, INSURANCE COMPANY OR GOVERNMENT AGENCY TO DISCLOSE OR FURNISH TO THE CSA RETIREE WELFARE FUND OR REPRESENTATIVES, ANY INFORMATION WITH RESPECT TO ANY ILLNESS INCLUDING MENTAL ILLNESS, DRUG/ALCOHOL ABUSE, INJURY, MEDICAL HISTORY, CONSULTATIONS, PRESCRIPTIONS, TREATMENTS OR BENEFITS, AND COPIES OF ALL APPLICABLE RECORDS THAT MAY BE REQUESTED. I UNDERSTAND THAT ANY INFORMATION OBTAINED PURSUANT TO THIS AUTHORIZATION WILL BE USED TO EVALUATE MY CLAIM. THIS AUTHORIZATION IS VALID DURING THE PENDENCY OF MY CLAIM. I UNDERSTAND I HAVE THE RIGHT TO REQUEST A COPY OF THIS AUTHORIZATION AND THAT A COPY WILL BE SENT TO ME IF REQUESTED. A PHOTOCOPY OF THIS FORM WILL BE AS VALID AS THE ORIGINAL.

SIGNATURE ____

(CLAIMANT OR CLAIMANTS DESIGNATED REPRESENTATIVE)

PRINT NAME ____ DATE _____-______-_____