PLAN ADMINISTERED BY
POMCO

ST. LAWRENCE UNIVERSITY

RETURN TO:

POMCO
P.O. BOX 6329
SYRACUSE, NY 13217
800-898-9715

MEDICAL/SURGICAL/MAJOR MEDICAL BENEFIT REQUEST FORM

E M P L O Y E E

PATIENT INFORMATION SECTION

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE: SELF / SPOUSE / CHILD / OTHER	3. SEX: M / F	4. PATIENTS DATE OF BIRTH: MONTH / DAY / YEAR

5. IF FULL TIME STUDENT GIVE NAME AND ADDRESS OF SCHOOL AND YEAR OF GRADUATION

6. EMPLOYEE NAME: FIRST / MIDDLE / LAST	7. EMPLOYEE SOCIAL SECURITY NUMBER
	- -

8. EMPLOYEE MAILING ADDRESS	EMPLOYEE'S BIRTH DATE	9. PROGRAM: ST. LAWRENCE UNIVERSITY
CITY, STATE, ZIP		10. IS TREATMENT A RESULT OF AN AUTO ACCIDENT? ☐NO ☐YES IF YES, GIVE DESCRIPTION AND DATE.

11. IS THE TREATMENT A RESULT OF AN ACCIDENT? ☐YES ☐ NO IF YES PLEASE DESCRIBE. HOW, WHEN AND WHERE?
IS TREATMENT DUE TO A WORK-RELATED CONDITION? ☐YES ☐NO

12. IS YOUR SPOUSE EMPLOYED? ☐YES ☐NO SPOUSE'S NAME	SPOUSE'S BIRTH DATE	SPOUSE'S SOCIAL SECURITY NUMBER
		- -

13. NAME, ADDRESS AND PHONE NUMBER OF SPOUSE'S EMPLOYER

14. IS THE PATIENT, YOUR SPOUSE, YOURSELF, OR ANY OTHER FAMILY MEMBER COVERED BY ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO IF YES, ANSWER QUESTION 15.
NAME OF FAMILY MEMBER COVERED

15. HEALTH PLAN NAME	GROUP NUMBER	NAME AND ADDRESS OF OTHER HEALTH INSURANCE COMPANY

16. I CERTIFY THE INFORMATION GIVEN BY ME IS COMPLETE AND CORRECT, AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE PATIENT NAMED. I AUTHORIZE ANY PHYSICIAN OR HOSPITAL TO PROVIDE PERTINENT RECORDS TO POMCO UPON REQUEST TO ESTABLISH MY CLAIM FOR BENEFITS UNDER THIS PLAN.

SIGNATURE OF COVERED EMPLOYEE DATE

17. I AUTHORIZE POMCO TO PAY ANY BENEFITS DUE TO THE PROVIDER I HAVE INDICATED.

SIGNED (EMPLOYEE) DATE PLEASE PAY DR.

P H Y S I C I A N

PHYSICIAN OR PROVIDER INFORMATION (SEE REVERSE FOR INSTRUCTIONS)

18. ONSET OF INJURY OR ILLNESS	19. DATE FIRST CONSULTED BY YOU FOR THIS CONDITION	20. IF EMERGENCY ILLNESS OR INJURY, BRIEFLY DESCRIBE.

PLACE OF SERVICES CODES
H - HOSPITAL
OP - OUTPATIENT
O - OFFICE VISITS
X - OTHER
L - LAB

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

DATE OF SERVICE	PLACE OF SERVICE CODE	DIAGNOSTIC CODE (ICD,DSM)	PROCEDURE CODE (CPT-4)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	FEE

PROVIDER NAME AND ADDRESS		TOTAL FEE CHARGED	
		AMOUNT PAID	
CITY, STATE, ZIP	TAXPAYER IDENTIFICATION NUMBER	BALANCE DUE	

I HEREBY CERTIFY THAT THE PROCEDURES INDICATED BY DATE HAVE BEEN COMPLETED.

DOCTOR'S SIGNATURE ________________ DATE ________

PHONE NUMBER ________________

POMCO®

HOW TO SUBMIT A CLAIM

TO THE PROVIDER:

1. HAVE THE PATIENT COMPLETE ITEMS 1 THROUGH 16 UNDER THE PATIENT INFORMATION SECTION. IF THE SUBSCRIBER IS MARRIED AND/OR HAS OTHER HEALTH BENEFITS, ITEMS 12 THROUGH 15 MUST BE COMPLETED. ANY MISSING INFORMATION MAY DELAY CLAIM PAYMENT.

2. IF THE PATIENT HAS OTHER COVERAGE WHICH IS PRIMARY (INCLUDING MEDICARE) YOU SHOULD FOLLOW YOUR NORMAL BILLING PROCESS. FOLLOWING PAYMENT BY THEIR PRIMARY CARRIER THE PATIENT MAY SUBMIT ANY UNPAID BALANCE TO POMCO BY FOLLOWING THEIR NORMAL CLAIM SUBMISSION PROCEDURES.

3. THE PROVIDER SHOULD COMPLETE ALL ITEMS UNDER THE PHYSICIAN'S INFORMATION SECTION. SINCE SCHEDULED PAYMENTS ARE DETERMINED BY THE PROCEDURE CODE USING THE CPT-4 TERMINOLOGY, YOU SHOULD USE THESE CODES WHENEVER POSSIBLE. YOU MAY ATTACH AN ITEMIZED STATEMENT AS LONG AS THE SAME INFORMATION IS AVAILABLE FROM IT. INDICATE YOUR USUAL FEE FOR THE SERVICES PERFORMED - NOT THE SCHEDULED PAYMENT AMOUNT. BE SURE TO INCLUDE YOUR TAXPAYER IDENTIFICATION NUMBER.

4. THE COMPLETED CLAIM FORM SHOULD BE RETURNED TO:

POMCO
P.O. BOX 6329
SYRACUSE, NY 13217

TOLL FREE NUMBER 1-800-898-9715

IMPORTANT REMINDER:
PLEASE BE SURE THE EMPLOYEE'S SOCIAL SECURITY NUMBER HAS BEEN PROVIDED.

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACTUAL MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME."