RETURN TO:
SCCEA, Inc.
1300 Veterans Memorial Highway
Suite 130
Hauppauge, NY 11788
(1-631) 231-3983

SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION WELFARE FUND

FULL-TIME EMPLOYEES ONLY

HOSPITAL INCOME CLAIM FORM

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name	Birth date	Relationship to Member Spouse ☐ Child ☐	Full Time College Student Yes ☐ No ☐	School

MEMBER/EMPLOYEE INFORMATION

Member Name	Birth date	Social Security#
Street Address / City / State / Zip		Telephone# ( )
Member's School or Work Location	Work Telephone#	

PHYSICIAN INFORMATION

Provider's Name (Print)		Telephone #	
Street Address	City	State	Zip Code
NAME OF HOSPITAL WHERE CONFINED			
ADDRESS	CITY	STATE	ZIP CODE

IS THIS CLAIM THE RESULT OF:
Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

DID CONFINEMENT OCCUR WHILE THIS PERSON WAS ON ACTIVE DUTY IN ANY MILITARY, NAVY OR AIR FORCE OF ANY COUNTRY? YES ☐ NO ☐

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize any insurance company, prepayment organization, employer, hospital, or dentist, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the information submitted by me in support of this claim is true and correct. **Authorization must be signed or payment will not be made.**

Signed (Member) SIGNATURE ON FILE IS NOT ACCEPTABLE ______________________ **Date** ______________

CERTIFICATION OF CONFINEMENT

CHECK ONE: COMPLETED BY ☐ **HOSPITAL** ☐ **ATTENDING PHYSICIAN**

Patient Name	Age	Date Admitted	Still Confined: / /	Date is charged: / /
Diagnosis from Records				

Date of any previous confinement From: To:	Is condition Due to Any Occupational Cause? Yes No
Completed by	Taken from Records On

Name	Title	Date
Address	Signature	

PLEASE ATTACH:

1. **A COPY OF THE HOSPITAL BILL WITH PATIENT NAME AND DATE OF SERVICE.**
2. **EXPLANATION OF BENEFITS FROM BASE MEDICAL PLAN.**