DOCTORS COUNCIL BENEFIT PLAN
50 Broadway 11th Floor, Suite 1101, New York, New York 10004 (212) 532-5995 Fax (212) 481-4137

☐ CURRENTLY EMPLOYED ☐ SELF-PAY COBRA

PLEASE COMPLETE THIS FORM AND SUBMIT IT POSTMARKED WITHIN ONE (1) YEAR FROM THE DATE OF SERVICE, ALONG WITH YOUR RECEIPT FOR SERVICE(S) RENDERED. WHERE APPLICABLE, YOU MUST ALSO SUBMIT STATEMENTS FROM OTHER INSURANCE CARRIERS.

RETURN TO:
Doctors Council Benefit Plan
50 Broadway, 11th Floor Suite 1101
New York, New York 10004
Phone: 212 532-5995 • Fax 212 481-4137

MEMBER INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #

ADDRESS *Street*	*City*	*State*	*Zip code*

HOME PHONE	WORK PHONE	FAX # EMAIL ADDRESS	WORK SITE

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	RELATIONSHIP TO MEMBER

IS PATIENT A FULL TIME STUDENT? YES NO	IS PATIENT COVERED BY ANOTHER INSURANCE PLAN? YES NO

NAME AND ADDRESS OF OTHER INSURER:

NAME AND ADDRESS OF OTHER INSURER:

BENEFIT YOU ARE APPLYING FOR: (CHECK ONE BOX ONLY)

☐ CHIROPRACTIC BENEFIT ☐ OPTICAL BENEFIT

☐ HOSPITAL INDEMNITY BENEFIT ☐ HEARING AID BENEFIT

PROVIDER INFORMATION : PROVIDER MUST COMPLETE THIS SECTION

NAME	ADDRESS	TELEPHONE NUMBER

DATE(S) OF SERVICE	DIAGNOSIS/DSM IV: (**HEARING AID ONLY**)	TREATMENT: For the Hearing Benefit indicate which ear(s) are affected.

PROVIDER'S SIGNATURE DATE	PROFESSIONAL DEGREE:	LICENSE NUMBER

MEMBER' S SIGNATURE	DATE

Office use only: Payment $_____ Approved By_____ Check Signed By_____