

DOCTORS COUNCIL BENEFIT PLAN B50 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 YEAR** (1) 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 <i>Street</i>	<i>City</i>		<i>State</i>	<i>Zip code</i>
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? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS PATIENT COVERED BY ANOTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME AND ADDRESS OF OTHER INSURER:				
NAME AND ADDRESS OF OTHER INSURER:				
NAME AND ADDRESS OF OTHER INSURER:				

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

<input type="checkbox"/> HEARING BENEFIT (<i>M.D. To Certify Below</i>)	<input type="checkbox"/> PODIATRY BENEFIT
<input type="checkbox"/> PSYCHIATRIC BENEFIT	<input type="checkbox"/> PRIVATE DUTY NURSING – IN HOSPITAL

PROVIDER INFORMATION : PROVIDER MUST COMPLETE THIS SECTION

NAME	ADDRESS	TELEPHONE NUMBER
DATE(S) OF SERVICE	DIAGNOSIS/DSM IV:	TREATMENT: For the Hearing Benefit indicate which ear(s) are affected.
MENTAL HEALTH PROVIDER MUST COMPLETE THE FOLLOWING:		
STATE LICENSED PSYCHOLOGIST	LICENSED CLINICAL SOCIAL WORKER (LCSW)	BOARD CERTIFIED PSYCHIATRIST BOARD ELIGIBLE PSYCHIATRIST
LENGTH OF EACH VISIT _____	CHARGE PER VISIT \$ _____	TYPE OF VISIT: INDIVIDUAL GROUP
PROVIDER'S SIGNATURE	DATE	PROFESSIONAL DEGREE: LICENSE NUMBER

MEMBER'S SIGNATURE

DATE

Office use only: Payment \$ _____

Approved By _____

Check Signed By _____