LOVE CANAL MEDICAL FUND, INC.

Please complete these forms carefully according to instructions. Your claim will be delayed if it is not properly and completely filled out and mailed to the correct address. LCMF is not an insurance company. Refer to your copy of the Love Canal Medical Trust Fund Medical Benefits Plan for further details

All medical bills must be submitted no later than 24 months from the date of service, or 12 months after receipt of the "Explanation of Benefits" (EOB) form provided by your insurance company, whichever comes later.

Completed Medical Benefit claim forms and related documentation must be submitted to:

Key Insurance & Benefits Services
Attn: Love Canal Medical Fund
239 Van Rensselaer Street
Buffalo, NY 14210
(716) 849-8177 OR (800) 899-3078

****INSTRUCTIONS FOR COMPLETING AND SUBMITTING CLAIM FORMS****
(Parts A, B, and C)

1. Collect your documentation.

2. Gather your bills from doctors, hospitals, and other medical service providers.
   Make PHOTOCOPIES of everything for YOUR records.

3. Gather copies of forms or statements received from health insurance companies or other medical benefit programs showing amounts paid or not paid by them.

4. Prepare Parts A and B **(one for each person submitting a claim).**
   Additional claim forms are available:
   - By writing to: **LCMF, P.O. Box 224, Lewiston, NY 14092-0224**
   - By email to: **lovecanalfund@gmail.com**
   - Downloading from website: **www.lcmf.org**
   - By calling LCMF at: **(716) 773-6578**

5. **Sign your own claim on the signature line at the end of Part A. You must also sign for any person for whom you are making a claim if that person is under your legal guardianship.**

6. There is a **$100 Deductible** per person per year for medical benefits claims.

7. List each of your bills on the **PART B, WORKSHEET**. For each expense, deduct the amount covered by your insurance making sure to include any deductible applied by your insurance carrier. Then, total the amount of expenses to be submitted to the LCMF. Make sure the total amount submitted to LCMF is higher than the deductible. **If the amount is lower than the LCMF $100 deductible, do not submit the claim**. If the amount is higher, follow the next set of instructions.

8. Complete and sign the Part "C" form. Your claim cannot be processed unless you sign this form. If we require additional Part "C" forms, we will make photocopies.

LOVE CANAL MEDICAL FUND, INC.

CLAIM FORM - PART A (*complete all questions by printing legibly or typing*)

1. Patient's Full Name (First, Middle, Last) Date of Birth Social Security # **(first time filers only)** Sex

_____ __/__/__ _____ M F ○ ○

2. Patient's Address: (City, State, Zip Code)

_____

3. Your name if you are the legal guardian for the patient. Relationship to patient

_____ _____

Your address: _____

4. Primary Health Insurance Company: Name & Address Telephone Number

_____ _____

5. Certificate No. / Policy No./ or Account No. of Primary Health Insurance Company:

_____ _____

6. Secondary Health Insurance Company's Name and Address Telephone Number

_____ _____

7. Certificate No. / Policy No./ or Account No. of Secondary Health Insurance Company:

_____

8. Name, address and telephone number of Employer of Patient Telephone Number

_____ _____

9. Name, address and telephone number of Patient's spouse Telephone Number

_____ _____

10. Does the patient have other medical coverage, such as Medicaid, Medicare, Social Security Disability, Veteran's Administration or other program? ○ **YES** ○ **NO**

If YES, provide the name of program, certificate number, account number, or policy number:

_____

PATIENT or LEGAL GUARDIAN SIGNATURE **DATE**

_____ _____

LOVE CANAL MEDICAL FUND, INC.

CLAIM FORM -WORKSHEET PART B (*complete all questions by printing legibly or typing*)

1. Patient's Full Name (First, Middle, Last) Date of Birth Social Security Number **(first time filers only)**

_____ ___/___/____ _____

Please list information for each bill that is being submitted as part of this claim (if you need more room attach additional sheets).

	Provider / Doctor / Pharmacy	Diagnosis / Medical Problem	Date of Service	Total Amount of Bill	Amount Paid by Insurance	Amount Submitted to Love Canal Medical Fund
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						

Total amount submitted to Love Canal Medical Fund: $ _____

NOTE: For each item above, you must submit documentation. Documentation consists of copies of bills from doctors, hospitals, or other providers of the medical services for which you are claiming benefits. Also submit copies of forms or statements you received from health insurers or other medical benefits program showing the amounts paid or not paid by them on your claim.

BE SURE TO KEEP PHOTOCOPIES OF EVERYTHING YOU SUBMIT!!!

LOVE CANAL MEDICAL FUND, INC.

CLAIM FORM -Authorization PART C (*complete all questions by printing legibly or typing*)

1. Patient's Full Name (First, Middle, Last) Date of Birth Social Security Number **(first time filers only)**

_____ ___/___/____ _____

2. Patient's Address Telephone Number

_____ _(___)_____

I AUTHORIZE you to release to **LOVE CANAL MEDICAL FUND, INC.** or its representatives, any and all information concerning advice, care, or treatment provided the patient, or deceased, including information relating to the mental illness, use of drugs or use of alcohol. I also AUTHORIZE my employer, group policyholder or benefits plan administrator to provide to LOVE CANAL MEDICAL FUND, INC. (also referred to as LCMF) or its representatives, insurance coverage information including benefits paid or payable, financial information or employment related information (A photocopy of this authorization shall be as valid as the original).

Love Canal Medical Fund, Inc. is in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) regulations. The Board and its business agents have undergone training to comply with HIPAA regulations.

Date: _____ _____

Patient or Legal Guardian Signature

MAIL TO:

Key Insurance & Benefits Services
Attn: Love Canal Medical Fund
239 Van Rensselaer Street
Buffalo, NY 14210

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