Please complete all sections of this form carefully according to instructions outlined below. Use this form when submitting for covered medical expenses and/or routine physical exam expenses. 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:

Future Comp/USI Insurance Services
Attn: Love Canal Medical Fund
726 Exchange Street, Suite 618
Buffalo, NY 14210
(716) 314-2076 OR (716) 314-2000

****INSTRUCTIONS FOR COMPLETING AND SUBMITTING CLAIM FORMS****

1. Collect your documentation.
2. Make **PHOTOCOPIES or SCAN** everything for **YOUR** records.
3. Gather copies of forms or statements received from health insurance companies or other medical benefit programs showing amounts paid, i.e., itemized summary of your visit with payment details or a paid receipt with an explanation of benefits (EOB).
4. Prepare Parts A and B (one for each person submitting a claim). Additional claim forms are available at:

lovecanalfund@gmail.com
www.lcmf.org
(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 minimum in total covered expenses per person per year required for submitting a claim to the Love Canal Medical Fund.
7. Claims will be processed twice a year in June and December. Checks will be cut after the LCMF Claims Committee's meetings in early July and January.
8. List each of your statements or explanation of benefits or on PART B, WORKSHEET. Ask your pharmacy(ies) for a year-end summary of all your prescriptions. Beginning January 2023, there is no deductible applied to covered medical expenses, routine physical exam expenses, or prescriptions submitted for reimbursement to the Love Canal Medical Fund. However, you must submit a minimum of $100 in total medical expenses. If you have less than $100 in routine physical exam expenses in a claim year and NO OTHER covered medical expenses, you may submit your routine physical exam expenses for reimbursement.
9. Complete Part "C" of this form and check the appropriate box indicating what expenses are being submitted. **Be sure to sign and date claim form**, as it cannot be processed without your signature. If we require additional Part "C" forms, we will make photocopies.

PART A *(Complete all questions by printing legibly or typing)*

1. **Beneficiary's Full Name: (First, Middle, Last)** | **Date of Birth:** MM/DD/19YY | **Social Security #:** (First Time Filers Only | **Sex:** M / F

2. **Beneficiary's Address:** | **City:** | **State:** | **Zip:**

3. **Beneficiary's Legal Guardian: (If Applicable)** | **Relationship to Beneficiary:**

   Beneficiary's Legal Guardian's Address: | **City:** | **State:** | **Zip:**

4. **Primary Health Insurance Company:** | **Phone Number:**

   Primary Health Ins. Address: | **City:** | **State:** | **Zip:**

   Certificate # / Policy # / Account # of Primary Health Insurance Company:

5. **Secondary Health Insurance Company's Name:** | **Phone Number:**

   Secondary Health Ins. Address: (If Applicable) | City: | **State:** | **Zip:**

   Certificate # / Policy # / Account # of Secondary Health Insurance Company: | **Phone Number:**

6. **Email Address:** *Please make sure to write clearly similar letters, numbers, and characters e.g., o or 0, 1 or l, - or _ , etc*

7. **Does the beneficiary have any other medical coverage, such as Medicaid, Medicare, Social Security Disability, Veteran's Administration or other program?**

   Name of Additional Program: | **Certificate #/Policy #/Account #:**

8. **Beneficiary/Legal Guardian Signature:** | **Date:**

PART B *(Complete all questions by printing legibly or typing)*

1. **Beneficiary's Full Name: (First, Middle, Last)** | **Date of Birth:** MM/DD/19YY | **Social Security #:** (First Time Filers Only)

Please list your medical visits in **chronological order** according to the date of your visit. Please remember that only medical visits/claims will be reimbursed if they are associated to with the toxins your were exposed to at the Love Canal. Visits/Prescriptions/Diagnostics for COVID-19, influenza, injuries, etc. will not be reimbursed. Please refer to your LCMF Benefits Plan or call (716) 314-2000 for further assistance. If you need more room, attach additional sheets.

	Date of Visit in Chronological Order	Provider (Doctor's Name)	Reason for Visit / Diagnosis / Medical Problem	Amount Beneficiary Paid
EX.	*1/3/2024*	*John Nichols*	*Anxiety*	*$15*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Total Physical Exam/Diagnostics/Medical Expenses Submitted: $

Please ask your pharmacy(ies) for a year-end summary of all your prescriptions. This should include the dates the prescription was filled, the name of the prescription, and the amount you as the beneficiary paid. You should cross out any prescriptions that are not related to the toxins from the Love Canal.

	Each Medication Listed First Date - Last Date Purchased	Prescription Name	Pharmacy	Amount Beneficiary Paid
Ex.	*1/4/24 - 12/12/24*	*Citalopram*	*Wegmans*	*60.00*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Total Prescription Amount Submitted: $

Total Amount Submitted: $

NOTE: For each item above, you must submit documentation. **Consider writing the number of the line from the PART B claim form on your matching documentation.** Documentation consists of copies of bills from doctors, hospitals, or other providers of the medical services for which you are claiming benefits. However, you must also submit copies of the statements you received from health insurers or other medical benefits programs showing the amounts the beneficiary paid on the claim.

BE SURE TO KEEP PHOTOCOPIES or SCAN EVERYTHING YOU SUBMIT!!!

PART C *(Complete all questions by printing legibly or typing)*

1. **Beneficiary's Full Name: (First, Middle, Last)** Date of Birth: MM/DD/19YY **Social Security #:** (First Time Filers Only)

2. **Beneficiary's Address:** **City:** **State:** **Zip:**

Please check ONE (1) of the following boxes:

☐ Claim includes medical expenses AND routine physical exam expenses.
A minimum of $100 is required before submitting.

☐ Claim ONLY includes routine physical exam expenses.
No minimum is required if you have no other expenses to

☐ Claim ONLY includes covered medical expenses.
A minimum of $100 is required before submitting.

☐ 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. complies 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.

BENEFICIARY or LEGAL GUARDIAN SIGNATURE: **DATE:**

MAIL TO:
Future Comp/USI Insurance Services
Attn: Love Canal Medical Fund
726 Exchange Street, Suite 618
Buffalo, NY 14210