GROUP EXCESS MEDICAL
STATEMENT OF CLAIM
FOR CO-INSURANCE BENEFITS
TO FILE:
ATTACH COPIES OF PAYMENT STATEMENTS
FROM ALL OTHER CARRIERS

EMAIL, FAX OR MAIL CLAIM FORM TO:

Municipal TPA Services LLC
500 Express Drive South - 1st Floor
Brentwood, NY 11717
Tel: (800) 893-6330 - Fax: (866) 938-0004
Service@MunicipalTPA.com
Attn: Meghan Lang

Suffolk County Police Benevolent Association
Group number
MTS557

MEMBER'S STATEMENT *(Complete for all claims)*

Member's Name (Last, First, Middle)	Member's Date of Birth	Member's Address (Street, City, State & Zip Code)
Coverage: ( ) Active ( ) Retired		

How May We Contact you during the day?	If you need additional forms, please indicate how you would like to receive them?
Phone: and/or email:	( ) Mail ( ) E-mail address

MEMBER EXPENSE INFORMATION

Patient's Name	**Date(s) of Service MM/DD/YYYY** Date of Service	**TYPE OF SERVICE Circle for each expense MD=Medical DD=Deductible HS=In Hospital Cash Benefit HN-In-Hospital Private Duty Nursing MH-Mental Health Benefit ***	Request Amount
		MD DD HS HN MH	
		MD DD HS HN MH	
		MD DD HS HN MH	
		MD DD HS HN MH	

---------- FOR THOSE WITH FAMILY COVERAGE ----------

SPOUSE or DEPENDENT EXPENSE INFORMATION

Patient's Name	**Date(s) of Service MM/DD/YYYY** Date of Service	**TYPE OF SERVICE Circle for each expense MD=Medical DD=Deductible HS=In Hospital Cash Benefit HN-In-Hospital Private Duty Nursing MH-Mental Health Benefit ***	Request Amount
		MD DD HS HN MH	
		MD DD HS HN MH	
		MD DD HS HN MH	
		MD DD HS HN MH	
		MD DD HS HN MH	

I hereby authorize any Insurance Company, Prepayment Organization, Employer or provider of medical services to release all information with respect to myself or 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 above information given by me in support of this claim is true and correct. A copy of this authorization shall be considered effective and valid as the original.

Any person who, knowingly and with intent to defraud any insurance company or other person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime

By signing below I am acknowledging under penalty of law that you have not received payment or reimbursement, from any insurance company or other independent policy, for the expenses which you are seeking coverage under this policy.

Member Signature	Patient Signature (Parent signature for minor)	Date