Transport Workers Union Local 100
Retirees Association
195 Montague St, 3rd fl., Brooklyn, NY 11201
Ph-212-873-6000 Ext 2161, 2077
Email: retirees@twulocal100.org

PLEASE REMIT CLAIMS TO:
MAGNACARE
1600 STEWART AVE., STE 200
WESTBURY, NY 11590
ATTN: MEMBER REIMBURSEMENT DEPT.

STATEMENT OF CLAIM

GROUP # 3219 MEMBER # _____

TO BE COMPLETED BY MEMBER

1. Mr./Mrs./Ms_____ Gender M___ F___ DOB ____/____/_____
2. Claim is made for: (Please Check One)
   Self _____ *Spouse* _____ *Beneficiary* _____
3. Payment should be made to: (Please Check One)
   Member _____ *Spouse* _____ *Beneficiary* _____
4. Home Address_____
   _____
5. Telephone # _____ SSN: _____

BENEFICIARY INFORMATION

Mr./Mrs./Ms _____ Last Name: _____ First Name: _____
SSN: _____-_____-_____ Date of Birth: _____
Address: _____
_____

*If member is deceased, please submit death certificate - Date of Death: ____/____/_____

I certify that the information entered above is true to the best of my knowledge and belief.
Date _____ Signature _____

ATTACH DISCHARGE LETTER or MEDICARE SUMMARY or ITEMIZED BILL CONFIRMING ADMITTANCE & DISCHARGE DATES

ATTENDING PHYSICIAN'S STATEMENT

1. Patients name_____ Patient DOB: _____/_____/_____
2. Date Admitted ____/____/_____ Date Discharged ____/____/_____
3. Nature of sickness or injury_____
4. When was sickness contracted or injury sustained _____
5. Indicate any physician who rendered previous treatment _____
6. Date performed _____ Operation by Dr._____
7. Where performed _____ If in hospital, inpatient _____ outpatient_____
8. What hospital _____

Physician's Name _____ Phone # _____

Physician's Signature _____ Date _____