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| **Administrative Services Only, Inc**<br>PO Box 9005, Dept. 11<br>Lynbrook, NY 11563-9005<br>**516-396-5500 / 800-537-1238**<br>**WWW.ASONET.COM** | **NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION BENEFIT FUND**<br>**INNER IMAGING BENEFIT CLAIM FORM**<br>**FOR ACTIVE MEMBERS** |

Please visit www.njdcea.org for additional plan information and claim forms
Please visit www.asonet.com to track your claims and claim history

## MEMBER INFORMATION

| MEMBER NAME | BIRTH DATE | MALE ☐ FEMALE ☐ | | |
|---|---|---|---|---|
| ADDRESS | APT. NO. | CITY | STATE | ZIP CODE |
| SOCIAL SECURITY NO. OR LAST FOUR DIGITS | WORK LOCATION | DAYTIME TELEPHONE NUMBER: | EVENING TELEPHONE NUMBER: | |

- The Fund will reimburse **ACTIVE MEMBERS** over 40 years of age the entire cost of a full body screening ($375).
- Body Screenings are performed at:

  Inner Imaging
  307 East 63 St.
  New York, NY 10065.

- The member must pay upfront and then submit a this claim form and receipt to the Administrative Services Only, Inc.
- This benefit can be used once every 10 years.
- This screening may determine your risk of future heart attack, lung disease, and many types of cancer long before any symptoms occur.
- Inner Imaging can be reached at 212-777-8900.

**TO FILE FOR REIMBURSEMENT**
**COMPLETE, SIGN AND RETURN THIS FORM TO ASO**
**ALONG WITH A COPY OF YOUR INNER IMAGING PATIENT RECIEPT**

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## MEMBER SIGNATURE – BENEFIT WILL BE PAID TO THE MEMBER

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED.

_____ _____
SIGNATURE OF MEMBER DATE