Administrative Services Only, Inc
PO Box 9005, Dept. 11
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238
WWW.ASONET.COM

NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION BENEFIT FUND INNER IMAGING BENEFIT CLAIM FORM 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
  165 E. 84th St.
  New York, NY 10028

- 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

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