CLAIM APPEAL FORM

NYSNA TCE FUND
Tuition and Continuing Education Fund

NAME:

_____

_____

MAILING ADDRESS:

_____

_____

TELEPHONE NUMBER:

_____

DATE OF BIRTH (MM/DD/YY):

_____

FACILITY AND JOB TITLE:

_____

_____

UNIT AND SERVICE:

_____

_____

NAME OF OFFERING (*course, seminar, workshop, etc.*):

_____

_____

NAME AND ADDRESS OF PROGRAM SPONSOR/COLLEGE:

_____

_____

_____

PROGRAM DATES (*from MM/DD/YY to MM/DD/YY*):

_____

NAME OF COURSE, COURSE NUMBER, OR NAME OF FEE:

_____

CHARGE(S): $_____

ASO CLAIM NUMBER (*found on Explanation of Benefits*):

_____

PLEASE EXPLAIN THE CIRCUMSTANCES OF YOUR APPEAL (*ATTACH ADDITIONAL DOCUMENTS AS NEEDED*):

_____

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_____

This completed Form, a copy of the Explanation of Benefits from ASO denying your claim, and **all supporting documentation** must be sent within sixty (60) days of the date of your claim's denial to: **John J. Barrett, Plan Administrator**, c/o New York State Nurses Association, 155 Washington Avenue, Albany, New York 12210 or Fax: 518-782-9530

I hereby swear that all information in this Claim Appeal Form and all other information/documentation I have provided to the NYSNA Tuition and Continuing Education Fund in support of my appeal are true and complete to the best of my knowledge.

Participant's Signature: _____ Date: _____

PLAN ADMINISTRATOR USE ONLY Date Received: _____ Appeal Number: _____