INSTRUCTIONS FOR OP505

1. **Required Enclosures:**
   a. Proof of Payment
      ie: Either copy of cancelled checks or copy of receipted paid bill on the doctors or vendor letterhead.
   b. Detailed bills that reflect the nature of the medical services rendered and prescriptions for items purchased. (CPT-4 code(s) per office visit and/or per treatment(s), including surgery) (See Below For Examples of Information Needed)
   c. Copy of the OP 198 approved by the Medical Bureau granting line-of-duty status for the period of absence.
   d. Accident and/or incident report.
   e. Notices of reimbursement from GHI, Medicare and private health insurance plans. GHI-CBP subscribers using partipating physicians should include copy of the reimbursement notices sent to their doctors by GHI.

2. **Mailing Instructions:**
   Sign the original OP 505 and one (1) copy. Mail original, copy and enclosures to:

   The New York City Board of Education
   Division of Personnel
   Claims Unit - Medical Bureau
   Room 10 - 2nd Floor
   65 Court Street
   Brooklyn, New York, 11201

EXAMPLES RE PARAGRAPH 1b. ABOVE

1. ANESTHESIA - How long administered (in hours and minutes)?
2. X-RAYS - What body part(s) was x-rayed. How many views were taken?
3. LABORATORY - What testing was done? Why? (Charge(s) per test MUST be shown)
4. PHYSICAL THERAPY - Length of session (in hours and/or minutes)?
5. PSYCHOTHERAPY - Lenigth of session (in hours and/or minutes)?
6. CPT-4 - Physician's Current Procedural Terminology - is a standard classification used to identify and report procedures and services performed by or under the direction of a physician.

NOTE

INSTRUCTIONS FOR OP505 and OP505A ARE IDENTICAL

NEW YORK CITY BOARD OF EDUCATION
DIVISION OF HUMAN RESOURCES
CLAIMS UNIT

2nd Floor - Room 10
65 Court Street, Brooklyn, N.Y. 11201
Telephone: (718) 935-2742

CLAIM FOR REIMBURSEMENT OF MEDICAL EXPENSES

SEE REVERSE SIDE FOR INSTRUCTIONS

PLEASE PRINT OR TYPE

NAME ______________________ SOCIAL SECURITY NUMBER: ______________

MAILING ADDRESS: ______________________ FILE NUMBER: ______________

____

1. TITLE: ______________________ 2. SCHOOL/OFFICE: ______________

3. SCHOOL/OFFICE ADDRESS: ______________________________

4. DATE OF ASSAULT: ______________________ 5. NATURE OF INJURY: ______________

6. DESCRIPTION OF ASSAULT: (If additional space is needed write on separate sheet and attach to claim)

____

____

____

____

____

____

7. WERE YOU ABSENT DUE TO INJURY? YES ☐ NO ☐ : If yes, see paragraph 1c of instructions.

8. CHECK HEALTH PLAN CURRENTLY ENROLLED IN AND CHOICE OF OPTIONAL BENEFITS RIDER:

HEALTH PLAN	NO OPTIONAL RIDER	OPTIONAL RIDER	UFT OPTIONAL RIDER
a. ☐ HIP/HMO	☐	☐	
b. ☐ MED-PLAN	☐	☐	
c. ☐ GHI-CBP	☐	☐	☐
d. ☐ GHI-TYPE C	☐	☐	

9. Are you or your spouse enrolled in any Private or Group Health Insurance Plans which provide coverage for any expenses incurred other than in section 8 above? YES ☐ NO ☐ If yes, please provide the following:

9a. Name of carrier ______________________________

Carrier address ______________________________

Policy holder ______________________ Policy number ______________

9b. Name of carrier ______________________________

Carrier address ______________________________

Policy holder ______________________ Policy number ______________

10. MEDICAL EXPENSES: $______________ (see §1a of Instructions)

11. REIMBURSEMENTS: $______________ (see §1d of Instructions)

Subtract Item 11 from Item 10. Remainder is entered in item 12.

12. AMOUNT CLAIMED: $______________

13. I hereby submit a claim for medical expenses as a result of an assault sustained in the line-of-duty. The facts in connection with the injuries are indicated above. This claim is made by me and submitted to the Board of Education with the intent that the Board of Education rely thereon in approving and paying my claim.

____ ______________
SIGNATURE OF CLAIMANT DATE

14. CERTIFICATE BY PRINCIPAL OR HEAD OF BUREAU

I hereby transmit herewith a claim submitted by ______________________________
to the best of my knowledge, information and belief, the facts contained under paragraphs 1 through 7 are substantially true.

____ ______________
SIGNATURE AND TITLE DATE

____
PRINT NAME

MAKE NO ENTRY BELOW THIS LINE (For Medical Bureau-Claims Unit use only)

Date Approved ______________ For Claims Unit: ______________________

Amount $ ______________

Date Disapproved ______________

AE-OOP 9918A (5-85) 03

OP 505A (6/89)