INSTRUCTIONS FOR FILING A LATE MEDICAL INSURANCE WAIVER 2012-2013

Step 1: Print out forms: Below (3 pages) **READ ALL INSTRUCTIONS**
2012-2013 Application, Verification and HIPPA privacy release

Student should fill in page 1 and page 3-Verification form **MUST** be filled in by private health insurance company and signed by authorized representative with a valid phone number for contact verification.

If you have Erie or Niagara County Medicaid –
Please **refer to following sheets** for example of acceptable proof of health insurance
Medicaid *outside of these counties is most cases emergency only coverage and will not be accepted without a contact signature and reachable phone number for verification.*
Fidelis participants **refer below** for example of acceptable proof of insurance.

Step 2: The application must be submitted in person (all 3 pages completed) to the SBI **Medical Insurance Office during the hours of 10:00 am and 3:00 pm Monday - Friday** (*due to staffing reasons*) One of the office staff members will attempt to contact your private health insurance company at the number listed on the verification form. If successful, you will need to submit a $50.00 late payment fee for processing or the waiver will not be completed. **Payment of the late processing fee can be made in cash or check payable to SUB BOARD ONE, INC. Payment can also be made at the SBI Ticket Office by credit card from 10am – 3pm.**

If the SBI – Medical Insurance Staff cannot reach your private insurance company then the student will be required to return at another time until the verification is complete.

The waiver window for the 2012-2013 academic year opened on July 12th, and closed October 12th, 2012. Any waiver submitted after the waiver window dates is considered a late waiver and subject to the late waiver process and fee. The waiver is an annual process that must be completed by Domestic students registered for 9 credit hours or more (graduate students), 12 credit hours or more (undergraduate students) and International students with as little as 1 credit hour. The health insurance is a mandatory fee and waiver is only permitted with insurance that meets or exceeds necessary requirements for attendance.

LATE WAIVER OPTION WILL CLOSE ON NOVEMBER 14TH, 2012

SBI
tudent Owned Services

STUDENT MEDICAL INSURANCE OFFICE
University at Buffalo • 223 Student Union, Buffalo, NY 14260
Tel: (716)645-3036 • Fax: (716)645-3465 • Web: www.healthinsurance.buffalo.edu

EXCEPTION WAIVER REQUEST
FALL 2012

Student Name: _____

UB Person Number: _____

UB-IT E-mail Address: _____

The final waiver deadline for the mandatory UB insurance assessment was **October 12, 2012**. If you carry private health insurance that meets or exceeds the requirements for waiver of the mandatory UB-AETNA program, and you have extenuating circumstances that prevented you from waiving prior to October 12, 2012, you may petition for waiver of premium and participation. In order to continue with this process, please verify that your private insurance policy was effective on or before **September 1, 2012**—if it was not, you cannot be considered for waiver for the **2012-2013** academic year.

Step One: Print and complete this entire form- Please make sure there is a signature at bottom of this page to verify you understand the requirements and terms of this exception waiver.

Step Two: Send the attached verification form **page 2** to your private health insurance company. This form **MUST** be signed by a Representative at your insurance company with a **valid/reachable telephone number** provided for contact and verification purposes. If the provider prefers they can answer the benefit questions on company letterhead. **A LETTER OF CREDIBLE COVERAGE WILL NOT BE ACCEPTED.**

Step Three: Return with completed application to the Student Medical Insurance Office Suite 223 Student Union (North Campus (*address in header*) *before* ***November 16th, 2012*:**

1.) This form completed and signed below.
2.) The attached verification form completed and certified by private insurance company **representative with a reachable phone number for verification purposes.**
3.) **Late Waiver Processing Fee of $50.00** in the form of cash, check or money order payable to "Sub-Board I, Inc". Additionally, the SBI Ticket Office can accept Master card, Visa, Discover and Campus Cash for payment
4.) **Signed HIPAA release** for enrollment/benefit information. We need **ONLY** the enrollment and general benefit portion. The Verification does **NOT** want access to any private health information.

—Student Acknowledgement and Certification—

I, the above named student, hereby petition for late waiver of the mandatory UB-AETNA policy. I agree to pay the appropriate late processing fee to "Sub-Board I, Inc" as a processing fee due to my waiver being submitted after the October 12, 2012 deadline. I agree to submit all paperwork requested above and realize that **my coverage will be verified by the UB Student Medical Insurance Office (SMI) to determine my eligibility for waiver as per the health insurance requirements for attendance at UB.** If my waiver cannot be granted, I may not be refunded the processing fee from SMI at 223 Student Union or Sub Board One, Inc. I understand and agree that all communication pursuant to this process will be e-mailed to my UB-IT e-mail address provided above. **Furthermore, I am fully aware that this is an annual online process to be completed each academic year that I am registered as an undergraduate carrying 12+ credit hours or a graduate/professional student carrying 9+ credit hours. Late Waiver applications will only be accepted once during your career at the University at Buffalo.**

Student Signature: _____ Date: _____ / _____ / _____

University at Buffalo
Insurance Verification Form

Copies of Insurance policies/CARDS and letters of Creditable Coverage are NOT acceptable.

The University at Buffalo requires all full-time students to maintain health insurance providing coverage for in-patient and out-patient, mental health, as well as catastrophic illness and injury. The student may satisfy the insurance requirements through private or employer sponsored plans that meet certain minimum criteria or through enrollment in a group insurance plan. **ERIE OR NIAGARA COUNTY MEDICAID AND FIDELIS MAY SUBMIT A MEMBERSHIP LETTER OF VERIFICATION IN PLACE OF THIS FORM.**

Section I (To be completed by Student)

Student Name: Last: _____ First: _____ Phone Number: _____

UB Person #: _____ Email Address : _____

Student Address: _____

City: _____ State: _____ Zip: _____

Section II (MUST be completed by an Insurance Company Representative)

Name of Insurance Company: _____

Member Name: _____

Member ID Number: _____ Country: _____

Group Number: _____ Policy Number _____

Effective Date: _____

Expiration Date: _____

I hereby attest that this plan meets the following standards:

Yes / No	The subscriber's plan offers A minimum coverage of at least $100,000 per medical condition?
Yes / No	Is this a Healthy NY Plan?
Yes / No	The subscriber's plan covers Inpatient and Outpatient medical care within 25 miles of the University at Buffalo campus area. ***Emergency Only coverage does not meet this requirement.***
Yes / No	The subscriber's plan covers Inpatient and Outpatient mental health care within 25 miles of the University at Buffalo campus area. ***Emergency Only coverage does not meet this requirement.***
Yes / No	The subscriber's plan provides prescription drug coverage (either as part of this medical plan or as a separate prescription plan). If prescription drug coverage is through a separate plan administrator, a copy of this form must also be completed by that provider.
Yes / No	The subscriber's plan is currently active and has been/will be effective from 9-1-2012 through 8-21-2013. (Please check here ____ if this plan requires periodic recertification for continuation.)

REQUIRED: PLEASE PRINT

VALID Insurance Carrier Phone Number

PLEASE MAKE SURE THIS INFORMATION IS READABLE FOR VERIFICATION PURPOSES.

Please Return To: Sub Board One
UB Student Medical Insurance Office
Suite 223 Student Union (North Campus)
Buffalo, NY 14260

Sub-Board I, Inc.

AUTHORIZATION for HEALTH CARE / HEALTH INSURANCE ADVOCACY

Information about you and your health is personal and Sub-Board I, Inc. (SBI) is committed to protecting the privacy of such information. In addition, your personal health information (PHI) is, in many cases, protected from use and disclosure by both State and Federal law. As a result, SBI will not use your PHI to advocate on your behalf with respect to health care or health insurance matters unless you sign this form permitting SBI to use your PHI for this purpose. Please carefully read this form and the information set forth below before signing.

Name: _____ UB PERSON# : _____-_____

Address: _____

_____

DOB: _____ Telephone #: _____(day) _____(eve)

I herby authorize representatives of SBI to receive information related to my private health insurance enrollment dates and benefit information

Dates for Verification:

October 13th, 2012 _____ (please insert date for verification permission to expire)

Providers:
Name of Insurance Company: _____
To include information related to enrollment dates and medical and mental health benefits

SBI-Student Medical Insurance Office Staff: _____
Verification Completed by: _____initial _____date

By providing this authorization, I give permission for representatives of SBI to discuss the medical care that I received from the above named providers, during the time period listed, as well as the actual or requested payment for such care, with both the providers and insurers listed above. I understand that I can rescind this authorization at any time thereby affecting future (but not past) communications.

_____
Signature of Patient (or Personal Representative[1])

_____
Print Name of Patient (or Personal Representative[1])

_____
Date

[1] As defined in 45 CRF §164.502(g)

ERIE COUNTY DEPT OF SOC SER
HOSPITAL UNIT POD18 ECMC
95 FRANKLIN STREET
BUFFALO, NY 14202

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE.

SE LE ENVIARA UNA COPIA EN ESPANOL DE ESTA NOTIFICACION EN UN SOBRE APARTE

NOTICE NUMBER:		DATE: January 24, 2012		CASE NUMBER:
OFFICE: MAE	UNIT: MA	WORKER: NYUTR	UNIT OR WORKER NAME: MEDICAID	TELEPHONE NO.: 716-858-8000

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	716-858-8000
OR Agency Conference	716-858-8000
Fair Hearing information and assistance	800-342-3334
Record Access	716-858-8000
Child/Teen Health Plan	716-858-8000

CASE NAME / AND ADDRESS

MAE/MA/NYUTR

IF YOU DO NOT AGREE WITH ANY DECISION EXPLAINED IN THIS NOTI[CE] [TO] ASK US FOR A CONFERENCE AND/OR ASK THE STATE FOR A FAIR HEARING. [AND/OR] FAIR HEARING SECTION TO SEE HOW TO ASK FOR A CONFERENCE.

MEDICAL ASSISTANCE

A Medicaid/Family Health Plus/Family [Planning] Benefit Program/Medicare [Assistance Program/Family] will be opened for the following individuals under the [Identification] Number noted below, effective

Name	Client I.D. #

This is because [assignment] of ERIE.

[Information] for Family Health Plus Enrollees

You will be [enrolled in the] same Family Health Plus (FHP) plan if it is offered in this county. [Enrollees] whose current plan is not available in this county will be assig[ned to a] plan. You will be notified about your new plan. You will be able to cha[nge] plans under certain circumstances. All FHP enrollees will receive a new me[mb]er packet from your new plan. If you have any questions about your health plan enrollment, call the managed care unit at the general phone number listed above.

Important Information for Family Health Plus-Premium Assistance Program Enrollees

The Family Health Plus-Premium Assistance Program will continue to make premium payments for your cost effective Employer Sponsored Health Insurance.

Important Information for Medicaid Managed Care Enrollees

You will be enrolled in the same Managed Care plan if it is offered in this county. Medicaid Managed Care enrollees whose current plan is not offered in your new county will need to use your New York State Benefit Identification Card to

FIDELIS CARE
NEW YORK

Membership Verification Letter

To Whom It May Concern:

Please accept this notification as method of verifying membership for the following Fidelis Care New York Member(s):

UB ID :

Name: **ID Number:**

D.O.B: **Plan:** Medicaid

Gender:

Effective Date: **Termination Date: N/A**

I hereby attest that this plan meets the following standards:

(YES) The subscriber's plan offer coverage of at least $100,000.00 per condition Per Policy Year

(YES) *The subscriber's plan covers inpatient and Outpatient ***mental & medical*** care within 25 miles of the University at Buffalo campus area. *Emergency Only coverage does not meet this requirement.* ***<Service with Participate in network provider for Erie County>***

(YES) The subscriber's plan provides coverage for pre-existing conditions or I have met the pre-existing waiting period of my plan.

(YES)*The subscriber's plan provides prescription drug coverage (either as p... or as separate prescription plan.)

(Not applicable) * The subscriber's plan is currently active and ... insurance coverage through the entire 2011/2012 academ...
<Local Department of Social Services handles r...

If you need additional information, please con... ...ment at 1-888- FIDELIS (1-888-343-3547)

Sincerely,

Member Services Super...

NORTHEAST REGION
8 Southwoods Boulevard
Albany, New York 12211
(518) 427-9584

...ER METROPOLITAN REGION
...5-25 Queens Boulevard
Rego Park, New York 11374
(718) 896-6500

WESTERN REGION
40 John Glenn Drive Suite 200
Amherst, New York 14228
(716) 564-3630

CENTRAL REGION
5010 Campuswood Dr.
Syracuse NY 13057
(315) 437-4875