REQUEST FOR BENEVOLENCE ASSISTANCE

This Form Must be completed to receive consideration for Payment:

***ALL BILLS AND INSURANCE STATEMENTS (E.O.B.'S) MUST ACCOMPANY THIS CLAIM.

Name:

First Name Last Name

Social Security Number:

Date Of Birth:

Month Day Year

Phone Number:

Please enter a valid phone number.

Do You Have Insurance:

Yes No

Address:

Street Address

City State

Licensed As:

Employer:

Hire Date

Month Day Year

Who Are Your Requesting Assistance For:

- Self
- Spouse
- Child

Request For (Select One):

- Medical
- Dental
- Vision
-

Brief Description Of Needs:

If Spouse Or Child, Please List Name And Date Of Birth:

Date Of Employer Signature

Month Day Year

If Racing Under A Partnership state The Name:

Has Claimant Or Employer Started Horses:

- ◯ Yes
- ◯ No

Determining Eligibility:

- ◯ To assist the Nebraska HBPA in determining my eligibility for the benevolence program. I authorize the release of any medical, dental, Insurance, or other HBPA affiliates records for myself or family member to: Nebraska Horsemen, Dba Horsemen's Benevolent & Protective Association

Privacy:

- ◯ I acknowledge that I have signed and reviewed the HBPA Employee Benefit trust fund privacy statement.

Date Of Signature

Day Year

Nebraska Horsemen's Benevolent & Protective Association

Authorization for Use & Disclosure of Protected Health Information

Name:

First Name Last Name

Social Security Number:

Date Of Birth

Month Day Year

Date Of Application

Month Day Year

Account/Health Record Number:

Authorization:

- I authorize Nebraska Horsemen's Benevolent & Protective Association, dbd Nebraska HorsemenPO Box 5656 Grand Island, NE 68802 to receive my free copy of the information from:

The following individually identifiable health information may be used and/or disclosed (Check All That Apply):

- ☐ Discharge Summary
- ☐ Face sheet
- ☐ Pathology Reports
- ☐ Reports of Lab Test
- ☐ Emergency Room Records
- ☐ Payment/Billing Records
- ☐ History & Physical Records
- ☐ Consultation Reports
- ☐ Psychotherapy Reports
- ☐ Reports of X-Rays
- ☐ Operative Reports
- ☐ _____

Dates Of Treatment To Be Released:

The above-mentioned health record is being requested to process my request for assistance with incurred charges.

I authorized the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological conditions, psychiatric/mental health treatment and/or HIV related conditions.

I understand that I have the right to revoke this Authorization, if the revocation is in writing and delivered to the Nebraska Benevolent & Protective Association. Any revocation will have no effect on any action taken by the Nebraska Benevolent & Protective Association in reliance upon this Authorization and prior to receiving any revocation.

By signing this Authorization, I acknowledge that I have read and understand this Authorization; I authorize the use and disclosure of my health information and in accordance with the terms of this Authorization. Further, I give authorization for any health information records to be sent to the Nebraska Benevolent & Protective Association via mail or email.

This authorization expires on December 31 of the current calendar year

Date Of Signature

Month Day Year