SUFFOLK COUNTY
SUPERIOR OFFICERS ASSOCIATION
BENEFIT FUND

2518 Montauk Highway, Brookhaven, New York 11719
Phone (631) 654-0900 Fax (631) 447-0977
www.suffolksoa.com

Member Name: _____ Member SSN (last 4): _____

Patient Name: _____ Patient DOB: _____

Member Address: _____ Phone: _____

_____

Claim Type:

☐ Hearing Aid *(Requires E.O.B.)*

☐ Hearing Aid Maintenance

☐ Foot Orthotics *(Requires E.O.B.)*

☐ Durable Medical Equipment *(Requires E.O.B.)*

☐ Lasik *(Member & Spouse only)*

☐ Ophthalmologist Refraction

☐ Ambulance Service

Date of Service: _____

**** Claim must be submitted within one (1) year of date of service with the required documentation, such as Explanation of Benefits (E.O.B.), receipts, or invoice indicating payment.**

_____ _____

Member Signature Date