# Statement of Claim For Group Medical Expense Benefits

## LOCAL UNION 831 EMPLOYER HEALTH & WELFARE TRUST FUND

MAIL TO: LOCAL UNION 831
P.O. Box 5528
El Monte, CA 91734
(626) 279-3080

## HOW TO FILE A CLAIM

1. COMPLETE THIS SIDE OF FORM, ANSWER **ALL** QUESTIONS.
2. COMPLETE THE TOP PORTION OF REVERSE SIDE OF THIS FORM AND SIGN THE AUTHORIZATION TO RELEASE INFORMATION.
3. HAVE ATTENDING PHYSICIAN COMPLETE REVERSE SIDE OF FORM.
4. ATTACH ITEMIZED BILLS – **IMPORTANT** – EACH BILL MUSH SHOW:
   **(1.) NAME OF PATIENT, (2.) DATE EACH EXPENSE WAS INCURRED, AND (3.) NATURE OF ILLNESS OR INJURY.**
   **IF THE BILL DOES NOT SHOW THIS INFORMATION, PLEASE WRITE IT ON THE BILL AND SIGN YOUR NAME.**
5. FORWARD COMPLETED FORM AND BILLS TO **THE ADMINISTRATOR** IN THE SELF-ADDRESSED ENVELOPE PROVIDED.
6. **DO NOT SUBMIT ANY ON-THE-JOB INJURY OR WORKERS' COMPENSATION CLAIM.**

## TO BE COMPLETED BY THE EMPLOYEE

**NAME (LAST, FIRST, MIDDLE INITIAL)** | **SOCIAL SECURITY NO.**

**HOME ADDRESS (STREET, CITY, STATE, ZIP CODE)** **IS THIS A NEW ADDRESS?** ☐ YES ☐ NO | **WEEKLY WAGE**

**DATE OF BIRTH** | **TELEPHONE NUMBER** | ☐ **MALE** ☐ **FEMALE** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **SEPARATED**

**NAME AND ADDRESS OF EMPLOYER**

DO YOU HAVE MORE THAN ONE EMPLOYER? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS.

DO YOU HAVE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO IF YES, GIVE NAME, RELATIONSHIP AND FULL NAME AND ADDRESS OF EMPLOYER.

IS THIS CLAIM FOR A DEPENDENT? ☐ YES ☐ NO IF YES, GIVE NAME, DATE OF BIRTH, RELATIONSHIP MARRIED? ☐ YES ☐ NO | **SPOUSE'S DATE OF BIRTH**

**NATURE OF ILLNESS** | **DATE OF FIRST TREATMENT**

IS THIS CLAIM BASED ON AN ACCIDENT? ☐ **YES** ☐ **NO IF YES, COMPLETE THE FOLLOWING:**

DATE OF ACCIDENT | TIME ☐ **AM** ☐ **PM** | **WHERE DID ACCIDENT OCCUR?**

**HOW DID ACCIDENT HAPPEN?**

**HAS CLAIM PREVIOUSLY BEEN MADE FOR THIS PERSON UNDER THIS PLAN?** ☐ YES ☐ NO

HAVE YOU (OR DEPENDENT) PREVIOUSLY BEEN TREATED FOR THIS OR A RELATED MEDICAL PROBLEM? ☐ YES ☐ NO IF YES, STATE WHEN AND GIVE NAME(S) AND ADDRESS(ES) OF DOCTOR(S) AND HOSPITAL(S)

ARE ANY OF THE ILLNESSES OR INJURIES FOR WHICH THIS CLAIM IS BEING MADE RELATED TO EMPLOYMENT? ☐ YES ☐ NO

IF YOU HAVE BEEN UNABLE TO WORK, GIVE DATE OF FIRST FULL DATE NOT WORKED ..... GIVE DATE OF RETURN OR EXPECTED DATE OF RETURN TO WORK .....

ARE YOU ENTITLED TO REIMBURSEMENT OF ALL OR PART OF THESE EXPENSES THROUGH ANY OTHER COVERAGE *WHICH PROVIDES* MEDICAL BENEFITS OR SERVICES? ☐ YES ☐ NO

IF YES, GIVE NAME AND ADDRESS OF ORGANIZATION PROVIDING BENEFITS OR SERVICES

**I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by the Administrator or its representative. A photostatic copy of this authorization shall be considered as effective and valid as the original.**

**Patient's Signature if Claim is for dependent other than minor child** .....

**Dated** ..... **Signature of Employee-Insured** .....

**To authorize payment of benefits directly to your physician, complete authorization to pay benefits section on reverse side.**

**Administered by: ATPA**

# Health Insurance Claim Form

## PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME *(First name, middle initial, last name)*

4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*

5. PATIENT'S GENDER
MALE ☐ ☐ FEMALE

6. INSURED'S I.D. NO.

7. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. *(Or Group Name)*

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
YES ☐ ☐ NO
B. AN AUTO ACCIDENT
YES ☐ ☐ NO

11. INSURED'S ADDRESS *(Street, city, state, ZIP code)*

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
*I AUTHORIZE THE RELEASE O ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM*
I declare and certify that the foregoing statements made by me are true to the best of my knowledge and belief. I am aware that if any of the statements made by me are willfully false I may be subject to criminal and civil penalties

*SIGNED* *DATE*

13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW*

*SIGNED (Insured or Authorized Person)*

## PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES ☐ ☐ NO

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES ☐ ☐ NO

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1, 2, 3, ETC OR DX CODE
1
2
3

☐ Check here if for Second Surgical Opinion

| 24. A DATE OF SERVICE | B* PLACE OF SERVICE | C FULLY DESCRIBE PROCEDURES MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN<br>PROCEDURE CODE (IDENTIFY ) | *(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)* | D DIAGNOSIS CODE | E CHARGES | F |
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25. SIGNATURE OF PHYSICIAN OR SUPPLIER

26. YOUR SOCIAL SECURITY NO.

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

SIGNED DATE

30. YOUR EMPLOYER ID NO.

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & *TELEPHONE NO.*

32. ARE YOU BOARD CERTIFIED? ☐ YES ☐ NO

33. YOUR PATIENT'S ACCOUNT NO.

34. SPECIALTY

I.D. NO.

* PLACE OF SERVICE CODES

1 — (IH) — INPATIENT HOSPITAL
2 — (OH) — OUTPATIENT HOSPITAL
3 — (O) — DOCTOR'S OFFICE
4 — (H) — PATIENT'S HOME
5 — DAY CARE FACILITY (PSY)
6 — NIGHT CARE FACILITY (PSY)
7 — FREE STANDING SURGICAL CTR
8 — (SNF) — SKILLED NURSING FACILITY
9 — AMBULANCE
O — (OL) — OTHER LOCATIONS
A — (IL) — INDEPENDENT LABORATORY
B — IMMEDIATE CARE CENTER