

**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 MUST 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DATE OF BIRTH	TELEPHONE NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 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 <input type="checkbox"/> AM <input type="checkbox"/> PM	WHERE DID ACCIDENT OCCUR?
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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 WORKEDGIVE 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 <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. INSURED'S I.D. NO.
	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	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 <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <i>I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM</i> 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		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNED _____	DATE _____	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 <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
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		
<input type="checkbox"/> 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 PROCEDURE CODE (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F
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.	I.D. NO.		
34. SPECIALTY					

* PLACE OF SERVICE CODES

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