

HEALTH PLAN BENEFITS

I.B.U. NATIONAL HEALTH BENEFIT PLAN

PMB #116, 5331 S Macadam Ave., Suite 258

Portland, OR 7239

Portland Area (503) 224-0048 All Other Locations (800) 547-4457

PART 1: MUST BE COMPLETED BY EMPLOYEE

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|---|--|--|--|---|--|
| 1. PATIENT'S NAME (First name, middle initial, last name) | | 2. PATIENT'S DATE OF BIRTH | | 3. EMPLOYEE'S NAME, ADDRESS AND PHONE NO. | |
| FULL TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE | | | | | |
| 4. PATIENT'S ADDRESS (if different from employee) | | 5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> | | 6. EMPLOYEE'S SOC. SEC. NO. | |
| 9. IS PATIENT ALSO COVERED BY ANOTHER GROUP HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, List Plan Name, Employer and Address | | 7. PATIENT'S RELATIONSHIP SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> | | 8. EMPLOYER LOCATION | |
| | | 10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/> | | 11. IF AN ACCIDENT <input type="checkbox"/> A.M. date _____ 20____ and time _____ <input type="checkbox"/> P.M. description (how & where) _____ | |

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|---|--|--|--|
| 12. AUTHORIZATION TO RELEASE INFORMATION | | 13. AUTHORIZATION TO PAY BENEFITS TO PROVIDERS | |
| PATIENT OR PARENT RELEASE SIGN BELOW I hereby authorize any insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. X _____ DATE _____ PATIENT OR PARENT (IF MINOR) | | IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW I hereby authorize payment of benefits directly to any providers of services, but not to exceed the usual, reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization. X _____ DATE _____ EMPLOYEE | |

PART 2: TO BE COMPLETED BY PHYSICIAN (OR ATTACH ITEMIZED BILL)

| 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 & 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 D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE 1. 2. 3. 4. | | | | | | | | |
| 24. A DATE OF SERVICE | B* PLACE OF SERVICE | C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) | | | D DIAGNOSIS CODE | E CHARGES | F | |
| | | PROCEDURE CODE* (Identify) | | | | | | |
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| 25. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____ | | | 26. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER. | | 27. TOTAL CHARGE | | 28. AMOUNT PAID | 29. BALANCE DUE |
| | | | | | 30. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE 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 - (NH) - NURSING HOME
8 - (SNF) - SKILLED NURSING FACILITY
9 - AMBULANCE

O - (OL) - OTHER LOCATIONS
A - (IL) - INDEPENDENT LABORATORY
B - OTHER MEDICAL/SURGICAL FACILITY

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HOW TO REQUEST BENEFITS

1. CLAIM FORMS ARE AVAILABLE AT WWW.IBUBENEFITS.ORG AND YOUR PERSONNEL OFFICE
2. COMPLETE THE “PATIENT INFORMATION” (ITEMS 1 THROUGH 12) ON THE REVERSE SIDE OF THIS FORM.

If you wish your benefits paid directly to your provider sign item 13.

3. HAVE YOUR PHYSICIAN COMPLETE THE “PHYSICIAN OR SUPPLIER INFORMATION”.
4. ATTACH THE COMPLETED “BENEFIT REQUEST FORM” TO THE BILLS AND MAIL THEM TO THE PLAN ADMINISTRATOR AT THE FOLLOWING ADDRESS BELOW.
5. A SEPARATE FORM MUST BE SUBMITTED FOR EACH FAMILY MEMBER FOR WHOM A CLAIM FOR BENEFITS IS BEING MADE.

WHERE TO FILE A CLAIM:

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TO CHECK YOUR ELIGIBILITY – CALL THE ADMINISTRATION OFFICE

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