

HEALTH PLAN BENEFITS

HARRISON ELECTRICAL WORKERS TRUST FUND
 PMB #116
 5331 S Macadam Avenue Ste 258
 Portland, OR 97239
 In Portland Area (503) 224-0048
 All Other Locations 1-800-547-4457

PART 1: MUST BE COMPLETED BY EMPLOYEE

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	
		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) _____	

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 _____ PATIENT OR PARENT (IF MINOR) DATE		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 _____ EMPLOYEE DATE	

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

14. DATE OF: *	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY	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. DATE OF ESTIMATED BABY DELIVERY: *	

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 SER- VICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D DIAGNOSIS CODE	E CHARGES	F
		PROCEDURE CODE* (Identify)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)			

25. SIGNATURE OF PHYSICIAN OR SUPPLIER*		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
SIGNED _____		DATE _____		30. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.*		

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|------------------------------------|-------------------------------|--------------------------------------|-----------------------------------|
| 1 - (IH) - INPATIENT HOSPITAL | 4 - (H) - PATIENT'S HOME | 7 - (NH) - NURSING HOME | 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 FACILITY | 6 - NIGHT CARE FACILITY (PSY) | 9 - AMBULANCE | B - OTHER MEDICAL/SURGICAL |

IF FILING A CLAIM FOR WEEKLY DISABILITY BENEFITS, #14-30 MUST BE COMPLETED BY YOUR PHYSICIAN

