Operating Engineers Local 501 Security Fund

Member Reimbursement Claim Form

PO Box 990
West Covina, CA 91793
Phone: (626) 646-1079 or (800) 320-0106, E-Fax: (626) 262-4722

Information Required for Processing:

- ✓ Itemized bill reflecting proof of payment
- ✓ Provider's name, address, phone number & Tax ID
- ✓ Procedure Code (CPT) and Diagnosis Code (ICD)
- ✓ Cash register receipts alone are not acceptable

Member's Name: _____

Member's DOB: _____ Alt ID or Last 4 SSN: _____

Address: _____

Phone Number: (Home) _____ (Work) _____ (Cell) _____

Patient Name: _____ Patient's DOB: _____

Provider's Name: _____ Tax Id: _____

Provider's Address: _____

Provider's Phone #: _____

CPT: _____ _____ _____ _____

ICD: _____ _____ _____ _____

Date of Service	Provider	Billed Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Member's Signature: _____ Date: _____

Updated 07/13/18 MOG