SHEET METAL WORKERS LOCAL 104 HEALTH CARE PLAN

P.O. Box 1618*San Ramon, CA 94583
Telephone (800) 548-1771 or (925) 208-9994

STATEMENT OF MEDICAL CLAIM

PART 1 INSURED MEMBER COMPLETES

EMPLOYEE'S NAME (LAST) (FIRST) (INITIAL)

EMPLOYER NAME (OR COMPANY YOU WORK FOR)

ADDRESS

DATE EMPLOYED

EMPLOYEE'S DATE OF BIRTH

CITY, STATE

ZIP CODE

SOCIAL SECURITY NUMBER

LOCAL UNION NO.

HOME TELEPHONE NO.

CLAIM IS FOR ☐ Self ☐ Spouse ☐ Child

PATIENT'S NAME (FIRST) (LAST)

PATIENT'S RELATIONSHIP TO INSURED

☐ MALE ☐ FEMALE

PATIENT'S DATE OF BIRTH

IS PATIENT A FULL TIME STUDENT? ☐ YES ☐ NO

IF YES, NAME OF SCHOOL CURRENTLY ATTENDING

FOR QUARTER OF 19

STUDENT IS UNMARRIED AND DEPENDS UPON ME FOR SUPPORT ☐ YES ☐ NO

SPOUSE'S NAME

NAME AND ADDRESS OF SPOUSE'S EMPLOYER

DOES SPOUSE HAVE GROUP INSURANCE? ☐ YES ☐ NO

NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THIS CLAIM. (INCLUDING MEDICARE, CHAMPUS, ETC.)

SPOUSE'S DATE OF BIRTH

SPOUSE'S SOC. SEC. NO.

DID PATIENT'S WORK CAUSE THIS CONDITION ☐ YES ☐ NO

HAS A CLAIM BEEN FILED WITH THE WORKER'S COMPENSATION CARRIER? ☐ YES ☐ NO

FIRST DAY UNABLE TO WORK DATE HOUR ☐ A.M. ☐ P.M.

IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN

IF CLAIM IS FOR AN INJURY, COMPLETE THIS SECTION

DATE OF INJURY

TIME ☐ A.M. ☐ P.M.

WAS PATIENT AT WORK WHEN INJURED? ☐ YES ☐ NO

IF YES, FOR WHOM?

DID ANOTHER PERSON CAUSE YOUR INJURY? ☐ YES ☐ NO

HOW DID AND WHERE DID INJURY HAPPEN?

PATIENT'S AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE ANY DOCTOR OR OTHER HEALTH PRACTITIONER, AND ANY HOSPITAL OR OTHER INSTITUTION, TO FURNISH AND DISCLOSE TO THE ABOVE TRUST FUND OR ITS DESIGNATED REPRESENTATIVES ANY AND ALL MEDICAL OR OTHER INFORMATION REGARDING ANY MEDICAL, MENTAL, DENTAL OR PHYSICAL HISTORY, CONDITION OR TREATMENT WHICH IS PERTINENT TO THIS CLAIM. SUCH INFORMATION MAY BE DISCLOSED TO ANY OTHER EMPLOYEE WELFARE BENEFIT PLAN WHICH ALSO MAY BE LIABLE FOR ANY PART OF THS CLAIM.

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE'S SIGNATURE X ◀ SIGN HERE

DATE SIGNED

SPOUSE'S SIGNATURE (IF OTHER THAN EMPLOYEE) X ◀ SIGN HERE

PART 2

ASSIGNMENT OF BENEFITS (Read instructions above before signing)

I AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO THE PERSON OR ORGANIZATION NAMED BELOW NOT TO EXCEED THE BENEFITS OTHERWISE PAYABLE TO ME FOR THE SERVICES RENDERED.

DATE SIGNED

EMPLOYEE'S SIGNATURE X

PART 3 ATTENDING PHYSICIANS STATEMENT

1. PATIENT'S NAME

AGE

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

2. DIAGNOSIS AND CONCURRENT CONDITIONS (OR ICDA)

3. IS DISABILITY DUE TO WORK INCURRED CONDITION? YES ☐ NO ☐

IS DISABILITY DUE TO ALCOHOLISM OR NARCOTIC ADDICTION? YES ☐ NO ☐

IS DISABILITY DUE TO PREGNANCY? YES ☐ NO ☐

APPROX. DATE PREGNANCY COMMENCED

DATE(S) OF SERVICE(S)	OFFICE	HOME	INHOSP	OUTPAT	OTHER	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES	RVS PROCEDURE CODE(S)	CHARGE(S)	

IF MEMBER IS FILING FOR DISABILITY CREDIT, THESE QUESTIONS MUST BE ANSWERED BY THE ATTENDING PHYSICIAN

PATIENT WAS CONTINUOUSLY DISABLED (UNABLE TO WORK) ☐ YES ☐ NO FROM THRU

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK

IF ACTUAL DATE OF RETURN IS UNKNOWN, GIVE ESTIMATE AS TO THE DURATION OF THE DISABILITY

DOES PATIENT HAVE OTHER HEALTH INSURANCE OR HEALTH PLAN COVERAGE? (IF YES, PLEASE IDENTIFY) ☐ YES ☐ NO

IMPORTANT NUMBER IS REQUIRED BY LAW ▶

SOC. SEC. NO. OR TAX I.D.

DATE

PRINT OR TYPE PHYSICIAN'S NAME & DEGREE

SIGNATURE (Attending Physician) X

STREET ADDRESS

CITY OR TOWN

STATE

ZIP CODE

TELEPHONE

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