**TEAMSTERS LOCAL 922-EMPLOYERS HEALTH TRUST**
7130 COLUMBIA GATEWAY DRIVE, SUITE A
COLUMBIA, MD 21046
PHONE: 410-872-9500

**HEALTH INSURANCE CLAIM FORM—INSTRUCTIONS**
1. Employee completes Part 1 and Part 3.
2. Your doctor completes Part 4.
3. Your employer completes Part 2 if loss of work is involved.
4. Mail completed form and all bills to office at left.

## PART 1 — This part to be completed and signed by the employee claiming benefit for self or dependent (Please print or type)

EMPLOYEE'S NAME (LAST) (FIRST) (MIDDLE INITITAL) | NAME OF COMPANY YOU WORK FOR (Firm Name)

HOME ADDRESS (Number and Street) | DATE EMPLOYED | OCCUPATION | DATE OF BIRTH (Employee)

(CITY) (STATE) (ZIP CODE) | TELEPHONE NO. | SOCIAL SECURITY NO.

CLAIM IS MADE FOR ☐Self ☐Spouse ☐Child | NAME OF PATIENT (First) (Middle Initial) (Last) | ☐ FEMALE ☐ MALE | DATE OF BIRTH (Claimant)

NAME AND ADDRESS OF SPOUSE'S EMPLOYER | DOES SPOUSE HAVE OTHER GROUP INSURANCE? ☐ YES ☐ NO

NAME OF ANY INSURANCE CARRIER OR OTHER ORGANIZATION PROVIDING BENEFITS FOR THIS SICKNESS OR INJURY (Include Dependent's Insurance) | POLICY #

DESCRIBE SICKNESS OR INJURY | SPOUSE'S DATE OF BIRTH

ARE YOU STILL ACTIVELY EMPLOYED? ☐ YES ☐ NO | IF NO, WHAT WAS LAST DATE OF ACTUAL EMPLOYMENT?

If Disabled, Show First Date You Were Unable to Work DATE: TIME: ☐ AM ☐ PM | HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO | DATE OF RETURN TO WORK

WAS DISABILITY CAUSED BY YOUR WORK? ☐ YES ☐ NO | HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKMEN'S COMPENSATION CARRIER? ☐ YES ☐ NO | RESULT—

WAS TREATMENT REQUIRED BECAUSE OF AN INJURY? ☐ YES ☐ NO IF YES, EXPLAIN BELOW

DATE INJURED | TIME AM☐ PM☐ | HOW DID INJURY HAPPEN?

WHERE DID INJURY HAPPEN? | WAS INJURY DUE TO AUTO ACCIDENT? ☐Yes ☐No

WAS CLAIMANT AT WORK WHEN INJURY HAPPENED? IF "YES", FOR WHOM
☐ YES
☐ NO

The above answers are true and correct to the best of my knowledge, I hereby authorize any physician, surgeon, practitioner or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A photostat of this authorization shall be as valid as the original.

(DATE) (EMPLOYEE'S SIGNATURE) (DATE) (CLAIMANT'S SIGNATURE—IF NOT A MINOR)

ITEMIZED BILLS MUST ACCOMPANY CLAIMS FOR HOSPITAL, SURGICAL AND MEDICAL EXPENSE BENEFITS

## PART 2 — To be completed by employer when applicable

1. Date Employee Employed _____ 19____ Date Employee Last Worked _____ 19____ Date Employee Returned to Work _____ 19____
2. Check Reason for Employee Leaving Work:
   Injured ☐ Sickness ☐ Quit ☐ Temporary Layoff ☐ Other ☐ Vacation ☐ From _____ Through _____
3. EMPLOYEE'S BASIC WAGE AT DATE OF DISABILITY $ _____ ☐ Month ☐ Week
4. WAS EMPLOYEE ELIGIBLE FOR SICK PAY? ☐YES ☐NO DATES _____
5. EMPLOYEE'S OCCUPATION
6. IS DISABILITY DUE TO OCCUPATIONAL CAUSES ☐ YES ☐NO
7. HAS EMPLOYEE MADE CLAIM FOR WORKMEN'S COMPENSATION FOR THIS ILLNESS OR INJURY? ☐YES ☐NO
   IS EMPLOYEE ENTITLED TO SUCH BENEFITS? ☐ YES ☐NO
8. DO YOU HAVE KNOWLEDGE OF ANY OTHER INSURANCE COVERING THIS CLAIM? ☐ YES ☐ NO
   IF YES, NAME OF INSURANCE CARRIER _____

NAME OF COMPANY _____ TELEPHONE NUMBER _____

MAILING ADDRESS _____ (STREET) _____ (PRINT NAME AND TITLE)

_____ (CITY) (STATE) (ZIP CODE) _____ (SIGNATURE) (DATE)

**FUND OFFICE USE ONLY**

| CONTR QUARTER HOURS | CLASS CODE | EMPLOYER CODE |
|---|---|---|
| | | |

## PART 3 PATIENT AND INSURED (SUBSCRIBER) INFORMATION

| PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) | PATIENT'S DATE OF BIRTH | INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) |
|---|---|---|
| PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) | PATIENT'S SEX<br>MALE ☐ FEMALE ☐ | INSURED'S SOCIAL SECURITY NUMBER |
| | PATIENT'S RELATIONSHIP TO INSURED<br>SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ | **TEAMSTERS LOCAL 922-EMPLOYERS HEALTH TRUST**<br>7130 COLUMBIA GATEWAY DRIVE, SUITE A<br>COLUMBIA, MD 21046<br>PHONE: 410-872-9500 |
| OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OR POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER) | WAS CONDITION RELATED TO<br>A. PATIENT'S EMPLOYMENT<br>YES ☐ NO ☐ | INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)<br>TELEPHONE NO. |
| | B. ACCIDENT<br>AUTO ☐ OTHER ☐ | WHERE DID ACCIDENT OCCUR? |
| I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.<br>SIGNED DATE | | I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW<br>SIGNED INSURED OR AUTHORIZED PERSON |

## PART 4 PHYSICIAN OR SUPPLIER INFORMATION

| DATE OF: | ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) | DATE FIRST CONSULTED YOU FOR THIS CONDITION | IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES |
|---|---|---|---|
| DATE PATIENT ABLE TO RETURN TO WORK | DATES OF TOTAL DISABILITY<br>FROM THROUGH | | DATES OF PARTIAL DISABILITY<br>FROM THROUGH |
| NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY) | | | FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES<br>ADMITTED DISCHARGED |
| NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE) | | | |

A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE →
1.
2.
3.
4.

B.
EPSDT YES ☐ NO ☐
FAMILY PLANNING YES ☐ NO ☐
PRIOR AUTHORIZATION NO.

| A. DATE OF SERVICE FROM | TO | B. PLACE OF SERVICE | C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN<br>PROCEDURE CODE (IDENTIFY) | (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) | D. DIAGNOSIS CODE | E. CHARGES | F. DAYS OR UNITS | G. T.O.S. | H. LEAVE BLANK |
|---|---|---|---|---|---|---|---|---|---|
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| SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS). (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF) | | TOTAL CHARGE | AMOUNT PAID | BALANCE DUE |
|---|---|---|---|---|
| | YOUR SOCIAL SECURITY NO. | PHYSICIAN'S SUPPLIERS AND OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. | | |
| YOUR PATIENT'S ACCOUNT NO. | YOUR EMPLOYER ID NO. | ID NO. | | |

TEAMSTERS LOCAL 922-EMPLOYERS HEALTH TRUST HAS COORDINATION OF BENEFITS, AND SUBROGATION FOR MOTOR VEHICLE ACCIDENT CLAIMS, DOES NOT COVER WORKER'S COMPENSATION CLAIMS.

TO EXPEDITE CLAIMS PAYMENT, PLEASE INCLUDE THE INSURED EMPLOYEE'S SOCIAL SECURITY ON ALL CLAIMS. THIS IS THE POLICY NUMBER. IF CLAIM IS FOR ACCIDENTAL INJURY, OTHER THAN ON THE JOB OR MOTOR VEHICLE PLEASE STATE WHERE AND HOW ACCIDENT OCCURRED, i.e.: home, bike accident, etc.