United Brotherhood of Carpenters and Joiners of America
General Office and Staff Health and Welfare Plan

Medical, Dental or Vision
Reimbursement Claim Form

PO Box 1618
San Ramon, CA 94583
Phone: (702)415-2189, Fax: (702)357-8044

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: _____