

**Metropolitan D.C. Paving Industry
Employee Health & Welfare Trust Fund
7130 Columbia Gateway Drive, Suite A, Columbia, Maryland 21046**

PHONE
(410) 872-9500

ATTENDING PHYSICIAN MUST
COMPLETE REVERSE

This Side To Be Completed By Employee (Please Print Clearly)

Name and Home Address of Employee (Print) Mr. _____ Mrs. _____ Member of Local Union No. _____ Miss _____ Soc. Sec. No. _____ No. _____ Street _____ City _____ State _____ Zip _____				Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated Date of Birth _____ Month _____ Day _____ Year _____	
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Dependent's Information: (Complete Only If Claim Is For Dependent)

Name of Dependent _____	Date of Birth _____	Relationship ☐ Wife ☐ Husband ☐ Child ☐ Other..... (Relationship) _____	Marital status if other than spouse ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated
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List All Employers During Past Three Months: Start with Present

Employer Name, City and State	Local No.	From		To	
		Yr.	Mo.	Yr.	Mo.
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

Nature of Illness or Disability

Date you last worked Due to illness: _____ Month _____ Day _____ Year _____	Cause of Disability: _____ _____ _____ _____
If disability is due to an accident, state when, where and how it happened _____ _____ _____	
Was illness or injury due, in any way, to your occupation? ☐ Yes ☐ No if "YES" Explain _____ _____	
Date returned to work _____ Month _____ Day _____ Year _____	If you have filed for "Workmen's Compensation", complete the following Claim No. _____ Ins. Company Name and Address _____ Date Filed: _____ Month _____ Day _____ Year _____

Other Group Health Coverage

Is the person for whom claim is being made covered under any other group plan providing health benefits and/or Medicare? YES ☐ NO ☐	
If YES", complete the following	
(a) Person in whose name this other plan is carried _____	
(b) Name of Employer _____	
(c) Address of Employer _____	
(d) Name of insurance company or organization providing benefits _____	
(e) Address _____ Policy Number _____	

Authorization and Certification

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release any and all information with respect to this claim which may be necessary to determine any amount payable. I certify that the above statements and information are correct.	
Signed at _____ on _____ City and State _____ Mo. _____ Day _____ Yr. _____	Signature of Employee _____

If you wish payment to go directly to the Doctor, carefully read and complete the following. Otherwise, furnish PAID RECEIPTS.

Assignment: I hereby authorize payment directly to the physician of any benefits otherwise payable to me for services as described on reverse, but such payment shall not exceed the maximum allowable for such services I fully understand that I am financially responsible for all charges not covered by this Plan.	
_____ Mo. _____ Day _____ Yr. _____	Signature of Employee _____

ATTENDING PHYSICIAN'S STATEMENT

Spaced for Typewriter—Marks for Tabular Appear on this Line

PATIENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	AGE
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INSURED'S NAME IF PATIENT IS A DEPENDENT

14. DATE	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐	16a. IF AN EMERGENCY CHECK HERE. ☐
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF PARTIAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency)			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COL. D BY REF. NO. 1, 2, 3, ETC. or DX CODE A 1 2 3 4			10. WAS CONDITION RELATED TO A. PATIENTS EMPLOYMENT YES ☐ NO ☐ CHARGES B. ACCIDENT AUTO ☐ OTHER ☐	
20. A DATE OF SERVICE	B PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. DAYS CHARGES
17. DATE PATIENT ABLE TO RETURN TO WORK		26. HAS BILL BEEN PAID? IF YES, PAID RECEIPTS MUST BE FURNISHED YES ☐ NO ☐	27. TOTAL CHARGE	28. AMOUNT PAID
SIGNED		30. YOUR SOCIAL SECURITY NO.	29. BALANCE DUE	
32. YOUR PATIENTS ACCOUNT NO.		31. PHYSICIANS OR SUPPLIERS NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
		33. YOUR EMPLOYER I.D. NO.		
I.D. NO.				