HEALTH PLAN BENEFITS

HARRISON ELECTRICAL WORKERS TRUST FUND
PMB #116
5331 S Macadam Avenue Ste 258
Portland, OR 97239
In Portland Area (503) 224-0048
All Other Locations 1-800-547-4457

PART 1: MUST BE COMPLETED BY EMPLOYEE

1. PATIENT'S NAME *(First name, middle initial, last name)**	2. PATIENT'S DATE OF BIRTH*	3. EMPLOYEE'S NAME, ADDRESS AND PHONE NO.*
FULL TIME STUDENT ☐ YES ☐ NO IF YES, WHERE		
4. PATIENT'S ADDRESS *(if different from employee)*	5. PATIENT'S SEX MALE☐ FEMALE ☐	6. EMPLOYEE'S SOC. SEC. NO.*
9. IS PATIENT ALSO COVERED BY ANOTHER GROUP HEALTH PLAN? ☐ YES ☐ NO *If Yes, List Plan Name, Employer and Address*	7. PATIENT'S RELATIONSHIP SELF☐ SPOUSE☐ CHILD☐ OTHER☐	8. EMPLOYER
	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES ☐ NO ☐ B. AN ACCIDENT YES ☐ NO ☐	11. IF AN ACCIDENT ☐ A.M. date_____20_____ and time_____☐ P.M. description (how & where)_____

12. AUTHORIZATION TO RELEASE INFORMATION	13. AUTHORIZATION TO PAY BENEFITS TO PROVIDERS
PATIENT OR PARENT RELEASE SIGN BELOW* I hereby authorize any insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. X_____ PATIENT OR PARENT (IF MINOR) DATE	IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW I hereby authorize payment of benefits directly to any providers of services, but not to exceed the usual, reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization. X_____ EMPLOYEE DATE

PART 2: TO BE COMPLETED BY PHYSICIAN (OR ATTACH ITEMIZED BILL)

14. DATE OF: *	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN*			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(IF OTHER THAN HOME OR OFFICE)*			22. DATE OF ESTIMATED BABY DELIVERY: *

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

1.
2.
3.
4.

24. A DATE OF SERVICE	B PLACE OF SER - VICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) PROCEDURE CODE* (Identify)		D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER* SIGNED DATE	26. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER.	27.TOTAL CHARGE	28.AMOUNT PAID	29.BALANCE DUE
		30. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.*		

1 - (IH) - INPATIENT HOSPITAL
2 - (OH) - OUTPATIENT HOSPITAL
3 - (O) - DOCTOR'S OFFICE FACILITY
4 - (H) - PATIENT'S HOME
5 - DAY CARE FACILITY (PSY)
6 - NIGHT CARE FACILITY (PSY)
7 - (NH) - NURSING HOME
8 - (SNF) - SKILLED NURSING FACILITY
9 - AMBULANCE
O - (OL) - OTHER LOCATIONS
A - (IL) - INDEPENDENT LABORATORY
B - OTHER MEDICAL/SURGICAL

IF FILING A CLAIM FOR WEEKLY DISABILITY BENEFITS, #14-30 MUST BE COMPLETED BY YOUR PHYSICIAN

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THIS SECTION TO BE COMPLETED BY EMPLOYER (IF CURRENTLY EMPLOYED) OR UNION (IF NOT DISPATCHED) IF LOSS OF TIME IS INVOLVED

Date Employee Stopped work*	Has employee returned to work? Yes ☐ When?*	No ☐ When expected?*
Date: Employer or Union*	By*	Title
Mailing Address Street	City	State Zip

INSTRUCTIONS

BE CERTAIN TO VERIFY THAT RESERVE HOURS ARE SUFFICIENT TO WARRANT COVERAGE. THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE AND THE ATTENDING PHYSICIAN

Be Sure ALL questions are answered and ALL information requested is furnished. Fill out ALL * areas for maternity benefits.

For WEEKLY BENEFIT CLAIMS, the Employer or Union Business Manager must also compete and sign the above.

The Attending Physician's Statement on the reverse side MUST be completed.

Attach ITEMIZED bills from Hospital, Attending Physician, Surgeon, Etc. if claim is filed for these benefits.

HOW TO REQUEST BENEFITS

1. COMPLETE THE "PATIENT INFORMATION" (ITEMS 1 THROUGH 12) ON THE REVERSE SIDE OF THIS FORM.
   If you wish your benefits to be paid directly to your physician, sign item 13.
2. HAVE YOUR PHYSICIAN COMPLETE THE "PHYSICIAN OR SUPPLIER INFORMATION"; OR ATTACH ITEMIZED BILL.
3. ATTACH THE COMPLETED "BENEFIT REQUEST FORM" TO THE BILLS AND MAIL THEM TO THE PLAN ADMINISTRATOR AT THE ADDRESS BELOW.
4. A SEPARATE FORM MUST BE SUBMITTED FOR EACH FAMILY MEMBER FOR WHOM A CLAIM FOR BENEFITS IS BEING MADE.
5. PLEASE FILL OUT ALL ITEMS WITH * FOR MATERNITY

WHERE TO FILE A CLAIM:

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TO CHECK YOUR ELIGIBILITY – CALL THE ADMINISTRATION OFFICE

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