RETURN FULLY COMPLETED FORM TO: PLAN CODE 103

LOCAL 786, I. B. Of T. Building Material Health & Welfare Fund

300 S. Ashland Ave., Chicago, IL 60607 • PHONE: 312-666-1875 • FAX: 312-666-2258

Name of **MEMBER**_____ Last 4 of SSN XXX-XX-_____ Date of Birth _____

Home Address_____ Phone Number_____

Current Employer _____

Name of **PATIENT** _____ Date of Birth_____ Last 4 of SSN XXX-XX-_____

Is this CLAIM for **ACCIDENT?**_____ **or ILLNESS?**_____

If accident, where and how did accident occur?_____

_____

Describe accident here _____

_____ Date of Accident _____

DO YOU OR YOUR SPOUSE CARRY ANY GROUP INSURANCE THROUGH AN EMPLOYER THAT WOULD COVER ANY OF THE BILLS INVOLVED IN THIS CLAIM? Yes_____ or No _____

If yes, please give the following information regarding the INSURED PERSON on the other plan:

Name_____ Date of Birth_____ Last 4 of SSN XXX-XX-_____

Name of Employer_____ Insurance Company Name_____

Policy Number_____ Insurance Company Address_____

I hereby certify that the foregoing statement, including any accompanying statements, are true, correct, and complete. I will reimburse the Fund for any adverse payment made to me or on my behalf due to any misrepresentations or error on this form.

MEMBER SIGNATURE_____ DATE_____

Any person who knowingly and with the intent to defraud any insurance company, files a statement of claim containing materially false, incomplete or misleading information, is guilty of a crime.

STATEMENT OF **EMPLOYER:** {To be completed **ONLY** if claim is for **WEEKLY DISABILITY** benefits)

Company Name_____ Internal Revenue Tax Identification Number _____

Was the employee actively employed when disability began? Yes___ No__ If no, please explain:_____

_____

Dates of **total disability** (unable to work) from:_____ to_____

Employee returned to work (or is expected to return to work) on: _____

Was this disability the result of injury or illness arising out of or caused by his job? Yes___ No__

EMPLOYER SIGNATURE_____ DATE_____

IMPORTANT:

HAVE YOU SIGNED THIS FORM AND ANSWERED ALL QUESTIONS?

FOR OFFICE USE ONLY:
Co. Code___ Verified By___
Date Certified _____
Effective Date _____

STATEMENT OF **PHYSICIAN** (TO BE COMPLETED IF CLAIM IS FOR **DISABILITY BENEFITS** OR MEDICAL BENEFITS):

NAME OF **PATIENT**_____ DATE OF BIRTH_____

NAME OF INSURED_____

WAS PATIENT'S CONDITION RELATED TO EMPLOYMENT? YES___ NO___

DO YOU HAVE RECORD OF OTHER GROUP INSURANCE FOR THIS PATIENT? YES___ NO___

NAME OF COMPANY _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below* *SIGNED* *DATE*	*I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW* *SIGNED (Insured or Authorized Person)*
PHYSICIAN OR SUPPLIER INFORMATION	
DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) | DATE FIRST CONSULTED YOU FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
DATE PATIENT ABLE TO RETURN TO WORK DATES OF TOTAL DISABILITY FROM | THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH
NAME OF REFERRING PHYSICIAN	FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*	WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES

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

1.
2.
3.
4.

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 CHARGES	F

SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES NO LAST 4 OF SSN	TOTAL CHARGE | Amount PAID | BALANCE DUE PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & *TELEPHONE NO.*
YOUR PATIENT'S ACCOUNT NO	YOUR EMPLOYER I.D. NO.	I.D. NO.

• PLACE OF SERVICE CODES

1-(IH)	INPATIENT HOSPITAL	4-(H)	PATIENT'S HOME	7-(NH)	NURSING HOME
2-(OH)	OUTPATIENT HOSPITAL	5-	DAY CARE FACILITY (PSY)	8-(SNF)	SKILLED NURSING FACILITY
3-(O)	DOCIOR'S OFFICE	6-	NIGHT CARE FACILITY (PSY)	9-	AMBULANCE

0-(OL) OTHER LOCATIONS
A-(IL) INDEPENDENT LABORAIORY
B- OTHER MEDICAl/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74