

**PLUMBERS AND PIPEFITTERS' LOCAL 422  
HEALTH AND WELFARE FUND**

1000 Burr Ridge Parkway, Suite 200 - Burr Ridge, IL 60527  
(630) 960-3322



**EMPLOYEE'S STATEMENT**

**PROCESSING OF CLAIMS REQUIRES THAT YOU FULLY COMPLETE THIS FORM.**

Have your physician or provider complete the reverse side of this form or attach itemized bills AND (if applicable) corresponding "Explanation of Payment" statements from Medicare or primary insurance. **DO NOT SUBMIT BALANCE DUE STATEMENTS.**

**EMPLOYEE INFORMATION**

Name of Employee _____		Date of Birth _____		Home Local Union No. _____	
Home Address _____					
City _____		State _____		Zip Code _____ Telephone No. ( ) _____	
Social Security No. _____		Occupation _____		Active <input type="checkbox"/> Retire Date _____	
Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Date Of Social Security Award _____					

**\*NOTE:** If recently married or divorced, indicate date(s) \_\_\_\_\_

**OTHER INSURANCE INFORMATION NOTE: Attach copy of payment worksheet from other insurance or Medicare**

Do you or your dependents have **ANY** other health insurance?  YES  NO If YES please supply:

1) Name of the person insured \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

2) Insured person's Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Policy No. \_\_\_\_\_

3) Insurance company name \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

4) Address, City, State, Zip \_\_\_\_\_

**DEPENDENT INFORMATION - If claim is for a Dependent**

Name of Dependent \_\_\_\_\_ Relationship to Employee \_\_\_\_\_ Date of Birth \_\_\_\_\_

Is Dependent attending school?  YES  NO Is Dependent employed?  YES  NO If YES, where? \_\_\_\_\_

Name \_\_\_\_\_

Address, City, State, Zip \_\_\_\_\_

**\*NOTE:** Attach letter from registrar of college/university indicating hours enrolled per semester.

**SICKNESS/INJURY INFORMATION \*Required for all claims\***

Nature of sickness or injury \_\_\_\_\_

Date accident occurred or sickness first began \_\_\_\_\_ Date first treated \_\_\_\_\_

If injured, detailed description of **HOW** and **WHERE** accident occurred \_\_\_\_\_

If patient required treatment in a hospital, indicate date treated next to type of treatment:

1) Emergency Room \_\_\_\_\_ 2) Outpatient Surgery \_\_\_\_\_ 3) Admission - Discharge \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Name of physician(s) consulted 1) \_\_\_\_\_ 2) \_\_\_\_\_

Did injury or sickness occur in the course of **ANY** employment?  YES  NO

Have you or do you intend to file this claim under Workers' Compensation?  YES  NO

**EMPLOYEE MUST COMPLETE IF APPLYING FOR DISABILITY BENEFITS**

EMPLOYEE'S DISABILITY STATEMENT	Date Last Worked _____	Date Work Resumed _____	Might claim be covered by Workers' Compensation Law? <input type="checkbox"/> YES <input type="checkbox"/> NO
	<b>*(Reverse side of this form MUST be completed by Employee's Physician)</b>		

**EMPLOYEE'S SIGNATURE**

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative of any facts and or related records concerning the injury, illness, or treatment (including mental/nervous and substance abuse) of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Signed \_\_\_\_\_ Dated \_\_\_\_\_

# ATTENDING PHYSICIAN'S STATEMENT

Patient's name and address Age \_\_\_\_\_

Insured's name if patient is a dependent \_\_\_\_\_

## PHYSICIAN OR SUPPLIER INFORMATION

Is condition due to injury or sickness arising out of patient's employment? Yes  No  If "yes" explain.

Is condition due to an accident? Yes  No  If "yes" explain.

When did symptoms first appear or accident happen? Date \_\_\_\_\_

When did patient first consult you for this condition? Date \_\_\_\_\_

Has patient ever had same or similar condition? Yes  No  If "yes" state when and describe.

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency)				FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES				
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)				ADMITTED		DISCHARGED		
				WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE				
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE				YES <input type="checkbox"/> NO <input type="checkbox"/>		NO <input type="checkbox"/>		
A	1	2	3	4	EPSDT YES <input type="checkbox"/> NO <input type="checkbox"/> FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/>			
DATE OF SERVICE	PLACE OF SERVICE	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	T.O.S.	LEAVE BLANK
INCLUDE ALL CODE NUMBERS (CPT, ICD 9) AND SERVICE DESCRIPTIONS					TOTAL CHARGE	AMOUNT PAID	BALANCE DUE	

Is patient still under your care for this condition? Yes  No  Date \_\_\_\_\_  
If "no" give date your services terminated.

How long was or will patient be continuously totally disabled (Unable to work)? From \_\_\_\_\_ Thru \_\_\_\_\_

If Patient NOT released to return to work, DATE OF NEXT APPOINTMENT Date \_\_\_\_\_

To your knowledge does patient have other health insurance or health plan coverage? If "yes" identify. Yes  No

Date \_\_\_\_\_ Type or print physician's/supplier's name \_\_\_\_\_

Signature (attending physician) \_\_\_\_\_ Degree \_\_\_\_\_ Tax Identification \_\_\_\_\_ Telephone \_\_\_\_\_

Street Address \_\_\_\_\_ City or Town \_\_\_\_\_ State or Province \_\_\_\_\_ ZIP Code \_\_\_\_\_

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE  
I authorize the Release of any Medical Information and or related records necessary to Process this claim

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO  
PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_ SIGNED (Insured) \_\_\_\_\_