IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND

GROUP HEALTH INSURANCE CLAIM FORM

Forward Completed Form to:

IBEW-NECA Southwestern Health & Benefit Fund
P.O. Box 819015
DALLAS, TEXAS 75381-9015
(972) 980-1123 Metro (972) 263-8185

IMPORTANT! READ CAREFULLY

Part 1 — Worker completes in all cases.

Part 2 — Attending physician or surgeon completes in all cases.

PART I
WORKER COMPLETES IN ALL CASES

1. Worker _____ (Print Name) Employer _____ (Print Name)

2. Name of patient _____ (Print) Date of Birth _____ (Month) (Day) (Year) ☐ Female ☐ Male ☐ Single ☐ Married ☐ Divorced

3. Is patient a dependent? Yes ☐ No ☐ Relationship _____

   Full-time student? Yes ☐ No ☐ If yes, give name of educational institution _____

4. Is this patient's ailment due to injury or illness arising out of or in the course of employment? Yes ☐ No ☐

5. IS AILMENT DUE TO ACCIDENT? Yes ☐ No ☐ If yes, WHEN _____

   WHERE? _____

   HOW? _____

6. If Worker is married, is Worker's spouse employed? Yes ☐ No ☐

   If yes, give spouse's first name _____ Occupation _____

   Spouse's employer _____

7. Is patient covered for benefits by any other (a) group, blanket or franchise insurance; (b) Blue Cross, Blue Shield or other prepayment plan; (c) union, employer, trustee or employee benefit organization plan; or (d) any governmental program or coverage required or provided by statute? Yes ☐ No ☐

   If yes, give name and address of the school, employer, union or governmental agency, the policy number, and the name of the insurance company _____

IF PATIENT IS THE WORKER, ALSO COMPLETE LINES 8 AND 9

8. Date Worker last worked prior to current disability _____

9. First date physically unable to work _____ Date returned or available for work _____

MEDICAL AUTHORIZATION

I, the undersigned, request that a photostat of this authorization be accepted as effective as the original and hereby authorize all Physicians, Hospitals, Pharmacists, including U.S. Government, employers, and other agencies, to disclose, furnish copies or permit review and copy, any and all record information in connection with any past or present illness, injury, treatment or prescription (WHICH MAY INCLUDE DRUG, ALCOHOL, PSYCHIATRIC, HIV OR AIDS INFORMATION), of me or my dependents. Such information may be used to the extent deemed necessary by the Fund office to determine the validity or amount payable on account of this claim.

Dated _____ 19____ Signed _____ (Signature of Patient)

☐ **Please Check Here If Change Of Address** Signed _____ (Signature of Worker)

Your Mailing Address _____ (No. Street) (City) (State)

Home Local Union No. _____ Social Security No. _____

Phone # _____

Part 2 – Attending Physician's Statement

1. PATIENT'S NAME

DIAGNOSIS AND CONCURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICDA* USED, GIVE NAME):

2.

3. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☐ PREGNANCY? YES ☐ NO ☐ IF YES, APPROXIMATE DATE PREGNANCY COMMENCED. DATE

4. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO PRUDENTIAL YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES †	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE – IF USED (IF CODE OTHER THAN CPT** USED, GIVE NAME)	CHARGES

†O—Doctor's Office IH—Inpatient Hospital NH—Nursing Home
H—Patient's Home OH—Outpatient Hospital OL—Other Locations
*ICDA—International Classification of Diseases
**CPT—Current Procedural Terminology (current edition)

TOTAL CHARGES → $
AMOUNT PAID → $
BALANCE DUE → $

5. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

6. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

7. PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐ IF "YES" WHEN AND DESCRIBE:

8. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

9. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK).
FROM THRU

10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

11. DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY

12. DATE PHYSICIAN'S NAME (PRINT)

INDIVIDUAL HEALTH CARE PRACTITIONERS ENTER YOUR SOCIAL SECURITY NO.* →

ALL OTHERS ENTER YOUR EMPLOYER IDENTIFICATION NO.* →

SIGNATURE DEGREE TELEPHONE

STREET ADDRESS CITY OR TOWN STATE OR PROVIDENCE ZIP CODE

*UNDER SECTION 6109 OF THE INTERNAL REVENUE CODE, RECIPIENTS OF MEDICAL HEALTH CARE PAYMENTS ARE REQUIRED TO FURNISH IDENTIFYING NUMBERS TO PAYERS WHO MUST REPORT SUCH PAYMENTS TO THE INTERNAL REVENUE SERVICE.

APPROVED BY COUNCIL ON MEDICAL SERVICE, AMA 10-67

Claimant's Assignment (Read before signing)

To be completed and signed by the Claimant if direct payment by Company to surgeon or physician is desired. (This assignment may not be honored if signed by a dependent or person other than the claimant.)

Date

I hereby authorize the Fund's Insurance Carrier to pay directly to the above-named physician the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Group Policy and Certificate to the extent of his interest as established herein.

(Signature of Insured Claimant)