

MEDICAL CLAIM FORM

IMPORTANT! READ CAREFULLY
 *It is a crime to fill out this form with facts you know are false or to leave out facts you know are important.

- Participant must complete form and have attending physician complete reverse side.
- Return to this address as soon as possible:
BOILERMAKERS NATIONAL HEALTH AND WELFARE FUND
 754 Minnesota Ave., Suite 522
 Kansas City, Kansas 66101-2766

IF CLAIM IS FOR A DEPENDENT, GIVE NAME AND RELATIONSHIP

Name of Dependent _____ Date of Birth _____
(Month) (Day) (Year)

Relationship of Dependent to Participant _____ Male Female Single Married

FULL TIME STUDENT (Only if claim for child, age 19 to 23 and taking minimum 12 credit hours)

Yes No

IF YES, WHERE AND LAST DATE ATTENDED: _____

STATEMENT OF CLAIM

PARTICIPANT INFORMATION:

1. Participant's Name _____ Date of Birth _____
 Marital Status: Single Married Divorced (Month) (Day) (Year)

2. Home Address _____ Telephone No. _____

 (City) (State) (Zip Code) Participant's Social Security No. _____

3. Is this your first claim with the Fund? _____ Are you retired? _____

PATIENT INFORMATION:

4. Date sickness began or injury occurred _____ Date first medical expense incurred _____

5. State fully nature of sickness or injury _____

6. a. If injured, state fully how, when and where injury occurred. _____

b. Is this condition related to your occupation? Yes No

7. Has claim been filed or will claim be filed under any Worker's Compensation, any occupational disease law and/or any third party? If yes, explain. _____

8. Show the physician's name and address _____

9. Do you or patient have other Group Health coverage? Yes No. If answer is Yes, complete the following:

Plan Name _____ Effective Date _____ Name of Policy Holder _____ Social Security Number of Policy Holder _____

Plan Address _____ Telephone No. _____ Policy Number _____

Does Plan Follow Birthday Rule? YES NO

Employer's Name _____

10. Do you or patient have Medicare? Yes No. If answer is Yes, complete the following and submit a copy of the Medicare Card.

Plan Name _____ Name of Policy Holder _____ Social Security Number of Policy Holder _____

Plan Address _____ Policy Number _____

CERTIFICATION AND AUTHORIZATION: I/We certify that the above statements and answers, including any accompanying bills are true and complete to the best of our knowledge and belief. I/We know it is a crime to fill out this form with facts I/We know are false or to leave out facts I/We know are important. I/We authorize the Boilermakers National Health and Welfare Fund to release or request any medical or other information necessary to process this claim. A photocopy of this authorization shall be as valid as the original.

 Date Participant Signature Spouse Signature

MUST HAVE BOTH SIGNATURES AND DATE

ATTENDING PHYSICIAN'S STATEMENT

Patient's name and address	Birth Date
Covered participant's name if patient is a dependent (Indicate address if different from patient)	Participant's Social Security Number

AUTHORIZATION TO PAY: I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for the charges not covered by this authorization.

Date _____, 19 _____. Signed _____
(Participant)

1. (A) 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

2. (A) Is this examination for routine physical? Yes No

(B) Is condition due to injury? Yes No

Is condition due to injury or illness arising out of patient's employment? Yes No

If "Yes" explain how, when, where injury or illness occurred.

(C) Is condition due to pregnancy? Yes No

3. (A) When did symptoms first appear or accident happen? Date _____, 19____

(B) When did patient first consult you for this condition? Date _____, 19____

(C) Has patient ever had same or similar condition? Yes No

If "Yes" state when and describe

4. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN.		D DIAGNOSIS CODE	E CHARGES		F DAYS OR UNITS
		PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)				
				Total Charge	Amount Paid	Balance Due	

5. *PLACE OF SERVICE CODES
 1 — (IH) - Inpatient Hospital 4 — (H) - Patient's Home 7 — (NH) - Nursing Home 10 — (OL) - Other Locations
 2 — (OH) - Outpatient Hospital 5 — (AC) - Ambulatory Center 8 — (SNF) - Skilled Nursing Facility
 3 — (O) - Doctor's Office 6 — (IL) - Independent Lab 9 — Ambulance

6. Is patient still under your care for this condition? Yes No
 If "No" give date your service terminated. Date _____, 19 _____

Print Attending Physician's Name	Date	Degree	MUST BE INCLUDED UNDER AUTHORITY OF LAW		
		State License No.	Individual Practitioner's SS No.		
Attending Physician's Signature		Telephone	All Other's — Taxpayer ID No.		

Street Address	City or Town	State or Province	Zip Code	Do You Accept Medicare Assignments? <input type="checkbox"/> Yes <input type="checkbox"/> No
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More than one location Yes No New Address Yes No