UFCW Local 1459 and Contributing Employers Health & Welfare Fund

33 Eastland Street
Springfield, MA 01109-2348
(413) 733-0177 or Toll Free 1-800-634-2700

MEDICAL AND DISABILITY CLAIM FORM

INSTRUCTIONS FOR MAKING A CLAIM FOR BENEFITS:

1. **Answer all required questions on this side of form, and sign the bottom section.**
2. **If you want us to pay the hospital or doctor directly, sign the "Assignment of Benefits" section on the reverse side.**
3. **Have your doctor complete the "Physician or Supplier" section or attach an original itemized bill. The bill must include the patient's name, diagnosis, place, date and type of service, and the amount charged for each service.**
4. **If you are making a claim for SHORT TERM DISABILITY, your employer must fully complete the "Employer/Disability Information" section <u>and</u> your doctor must complete the "Physician or Supplier" section on the reverse side of the form.**

Employee Name (First, Middle, Last)	**Plan No.** K119	Social Security Number
Home Address	Date of Birth	Daytime Phone Number
	Marital Status ? Single ? Divorced ? Married ? Widowed	Work Status ? Active ? Disabled ? Retired ? Other (specify)
City State Zip		

PATIENT INFORMATION		**SPOUSE INFORMATION**	
Patient Name (First, Middle, Last)	Date of Birth	Spouse's Name (First, Middle, Last)	Spouse's Date of Birth
Relationship to Employee ? Self ? Spouse ? Child* ? Other(specify)	Sex ? Male ? Female	Spouse's Social Security Number	Employment Status ? Active ? Retired ? Not Employed
*Is Child Married? ? Yes ? No Full-time student? ? Yes ? No Are natural parents divorced or separated? ? Yes ? No Does natural parent WITHOUT custody have financial responsibility for health expenses? ? Yes ? No		Spouse's Employer Name and Address	

Describe sickness or injury. If injury, where and how did it occur?		
Date sickness began or injury occurred	Did injury occur at work? ? Yes ? No Was sickness caused by work? ? Yes ? No	Was injury caused by an automobile accident? ? Yes ? No If yes, specify city and state

OTHER INSURANCE DATA (Complete the following section if you or any member of your family is covered by any other health plan or Medicare)

Name of Person Covered by Other Insurance (First, Middle, Last)			Name and Address of Insurance Company
Relationship to You of Person Covered by Other Insurance ? Self ? Patient ? Spouse ? Other: specify relationship			
Policy or Plan No.	Ins. ID Number	Type of Coverage ? Individual ? Medical ? Family ? Dental	

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

AUTHORIZATION FOR RELEASE OF INFORMATION

I/We authorize the release to the UFCW Local 1459 and Contributing Employers Health & Welfare Fund and its agents of any evidence or information about me or my dependents that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original.

Employee's Signature _____ Date _____ Patient's Signature (if patient is legal adult) _____ Date _____

EMPLOYER / DISABILITY INFORMATION

1. From what date was the patient continuously employed?

6. Name of Employer	Employer's Tax ID Number
Address of Employer	
Employer's Telephone Number ( ) -	Form Completed By (Print Full Name and Title) / Date

ASSIGNMENT OF BENEFITS	I authorize payment of benefits to the undersigned physician or supplier for the services described below. Employee's Signature Date

PHYSICIAN OR SUPPLIER INFORMATION

(This section to be completed by a physician unless the claim is submitted with an itemized bill.)

Patient's Name (Print in full)		
Date of Illness (first symptoms), Injury (accident), or Pregnancy (LMP)	Date first consulted for this condition	Date patient able to return to work
Has patient ever had similar symptoms? ? YES ? NO If yes, when?		Dates of Total Disability From Through
Name of Referring Physician		Dates of Partial Disability From Through

Facility where the services were rendered (if other than home or office)

1 _____ _____	Admission Date	Discharge Date
2 _____ _____	Type Code	Source Code
3 _____ _____	Discharge Status Code	

	PLACE OF SERVICE*					

Physician's or Supplier's Name, Address, and Telephone Number (print)	Patient's Account Number	
	Physician's Tax ID Number	Amount Paid
		Balance Due

1. Inpatient Hospital
2. Outpatient Hospital
3. Doctor's Office
4. Patient's Home
5. Day Care Facility
6. Night Care Facility
7. Nursing Home
8. Skilled Nursing Facility
9. Ambulance
10. Other Locations
11. Independent Laboratory
12. Non-Hospital Surgical Ctr.