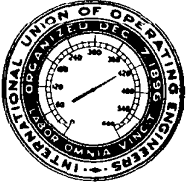

OPERATING ENGINEERS HEALTH AND WELFARE FUND

I.U.O.E. LOCAL 12
CLAIMS DEPT.
P.O. Box 7067, Pasadena, California 91109
Phone: **(626) 356-1004**

MEDICAL CLAIM FORM

TO BE COMPLETED BY MEMBER

ALL QUESTIONS MUST BE ANSWERED

AFFIX LABEL HERE

MEMBER'S SOCIAL SECURITY NUMBER

☐ MALE ☐ FEMALE

Member's Last Name First Middle

Member's Home Address

City - State - Zip Code

Member's Date of Birth: ____________

Home Phone: (   ) ____________

	Yes	No	
1.	☐	☐	Is this a Dependent Claim? If so, please complete Box 1A.
2.	☐	☐	Does Dependent work? If so, please complete Box 2A.
3.	☐	☐	Are you or dependent, (if dependent claim) insured under another group plan? If so, please complete Box 3A.
4.	☐	☐	Was this claim due to an accident? If so, please complete Box 4A.
5.	☐	☐	Is illness or injury due to claimant's occupation? If so, please complete Box 4A.

1A

First Middle Last ☐ Male ☐ Female

Name of Dependent

Date of Birth

Relationship to employee ☐ Spouse ☐ Son ☐ Daughter ☐ Other

If other please describe: ____________

2A

Dep. Soc. Sec. #

Employer Name

Employer Address

City, State, Zip

(   )
Employer Phone

3A

Policy #

Carrier Name

Address

City, State, Zip

(   )
Phone #

4A

Date of Accident Hour (am pm)

Location of Accident/Injury

DESCRIBE THE ACCIDENT

____

____

____

____

USE FOR CHANGE OF ADDRESS:

New Address

City, State, Zip

Effective Date: ____________

Member's Signature

****NOTE:** Without **member's** signature, change of address is **not** acceptable.

****ASSIGNMENT OF PAYMENT TO PROVIDER OF SERVICE**

I authorize payment of medical benefits to the designated physician or provider of service.

Member's Signature

3

INVENTORY # ____________

HAVE YOUR DOCTOR COMPLETE THE "PHYSICIAN OR SUPPLIER INFORMATION" (ITEM 5 THROUGH 19) OR SUBMIT COMPLETELY ITEMIZED BILLS.

An itemized bill is one that shows the patient's name, relationship, date of service rendered and the nature of the condition being treated, and the physician's or supplier's taxpayer identifying number. If this information is missing, please write it on the bill yourself and sign your name.

PHYSICIAN OR SUPPLIER INFORMATION

5. DATE OF: ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP) — DATE FIRST CONSULTED YOU FOR THIS CONDITION

6. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? Yes ☐ No ☐ IF YES, ENTER BRIEF DESCRIPTION & DATES

7. IS TREATMENT RESULT OF ACCIDENT? Yes ☐ No ☐ IF YES, ENTER BRIEF DESCRIPTION & DATES

8. ARE ANY SERVICES COVERED BY ANOTHER PLAN? Enter Plan Name and Address

9. NAME OF REFERRING PHYSICIAN

10. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office) — FOR SERVICES RELATED TO HOSPITALIZATION GIVE DATES

Admitted — Discharged

11. DIAGNOSIS/NATURE OF ILLNESS/INJURY, **RELATE DIAGNOSIS TO PROCEDURE IN CULUMN D BY REFERENCE TO NUMBER 1, 2, 3, ETC. 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

13 SIGNATURE OF PHYSICIAN OR SUPPLIER

DATE

14 TOTAL CHARGE | 15 AMT. PD. | 16 BALANCE

17 YOUR PATIENT'S ACCOUNT NO.

18 YOUR FEDERAL TAX ID NO.

19 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE, & TELEPHONE NO.

*PLACE OF SERVICE CODES

1 - (IH) - INPATIENT HOSPITAL
2 - (OH) - OUTPATIENT HOSPITAL
3 - (O) - DOCTOR'S OFFICE
4 - (H) - PATIENT'S HOME
5 - DAY CARE FACILITY (PSY)
6 - NIGHT CARE FACILITY (PSY)
7 - (NH) - NURSING HOME
8 - (SNF) - SKILLED NURSING FACILITY
9 - AMBULANCE
A - (IL) - INDEPENDENT LABORATORY
B - OTHER MEDICAL/SURGICAL FACILITY
O - (OL) - OTHER LOCATIONS