RETURN COMPLETED FORM TO:

SHEET METAL WORKERS' LOCAL 265, HEALTH & WELFARE FUND

205 Alexandra Way, Carol Stream, IL 60188-2080 – Phone (630) 668-7260, 668-7291
www.smw265.org • email benefits@smw265.org

EMPLOYEE'S STATEMENT

This claim form should be completed by the member and Physician when the doctor is not in the PPO or if the claim is for Loss of Time Benefits. If your doctor is in the PPO and the claim is not for Loss of Time Benefits, you could use this form but just complete your side and return to the Fund Office

EMPLOYEE INFORMATION

Name of Employee _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip Code _____ Telephone No. (____) _____

Health Card ID No. _____ Occupation _____ Active ☐ Retire Date _____

Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

***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 _____

Dependent's Social Security No. _____

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 _____

_____

Was there any hospital confinement, emergency room care or out patient surgery for this claim? If so, please show:

Type of Treatment	Dates of Treatment	Name of Hospital or Out Patient Facility

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 claim under Workers' Compensation? ☐ YES ☐ NO

If Accident, will claim be made against any auto insurance carrier or third party liability insurance carrier? ☐ 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? ☐ YES ☐ NO
	***(Reverse side of this form MUST be completed by Employee's Physician)**		

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.

Employees Signature _____ Dated _____ 20 ____

If claim for dependent over 17, Dependent's Signature _____ Dated _____ 20 ____

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

SIGNED (Insured) _____

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 _____ 20__

When did patient first consult you for this condition? Date _____ 20__

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
ADMITTED | DISCHARGED

NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*

WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE
YES ☐ NO

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

A
1
2
3
4

EPSDT YES ☐ NO ☐
FAMILY PLANNING YES ☐ NO ☐

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? If "no" give date your services terminated. Yes ☐ No ☐ Date _____ 20__

How long was or will patient be continuously totally disabled (Unabel to work)? From _____ 20__ Thru _____ 20__

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