SHEET METAL WORKERS' LOCAL 73 WELFARE FUND

4530 ROOSEVELT ROAD
HILLSIDE, ILLINOIS 60162
PHONE (708) 449-7373

MAJOR MEDICAL CLAIM FORM

1. MEMBER'S SOCIAL SECURITY NO. _____

   MEMBER'S NAME _____
   (FIRST) (MIDDLE INITIAL) (LAST)

   ADDRESS _____
   (STREET NUMBER) (CITY) (STATE) (ZIP CODE)

   HOME PHONE NO. _____

2. NAME OF SPOUSE _____
   (FIRST) (MIDDLE INITIAL) (LAST)

   SPOUSE'S SOCIAL SECURITY NO. _____

   IS SPOUSE EMPLOYED? ☐ NO ☐ YES SPOUSE'S EMPLOYER'S PHONE NO. _____

   SPOUSE'S EMPLOYER _____

   SPOUSE'S EMPLOYER'S ADDRESS _____

3. PATIENT'S NAME _____
   (FIRST) (MIDDLE INITIAL) (LAST)

   PATIENT IS: ☐ MYSELF ☐ SPOUSE ☐ CHILD PATIENT IS: ☐ MALE ☐ FEMALE

   PATIENT DATE OF BIRTH _____ PATIENT'S SOC.SEC.NO. _____

4. ARE THERE ANY OTHER MEDICAL BENEFITS AVAILABLE TO YOU, YOUR SPOUSE OR DEPENDENTS FROM OTHER GROUP INSURANCE PLANS: OTHER EMPLOYER; OTHER LABOR ORGANIZATION; PROFESSIONAL ORGANIZATION; BLANKET INSURANCE (SCHOOL, SPORTS OR TRAVEL GROUPS, ETC.); ANY STATE OR FEDERAL AGENCY; OR VETERAN'S ADMINISTRATION, MEDICARE, ETC.?

   ☐ I DO NOT HAVE OTHER INSURANCE. ☐ **YES. IF YES, THIS AREA MUST BE COMPLETED:**

   NAME OF OTHER INSURANCE COMPANY OR CLAIMS ADMINISTRATOR _____

   ADDRESS OF OTHER INSURANCE COMPANY _____

   _____ PHONE NO. _____

   NAME OF POLICYHOLDER _____ RELATIONSHIP OF POLICYHOLDER TO MEMBER _____

   POLICY NUMBER _____ EFFECTIVE DATE _____

   MEDICARE ELIGIBILITY: PART A ☐ NO ☐ YES IF YES, EFFECTIVE DATE _____
   PART B ☐ NO ☐ YES IF YES, EFFECTIVE DATE _____

5. PLEASE DESCRIBE THE CONDITION(S) FOR WHICH THE PATIENT RECEIVED THESE SERVICES:

   _____

   DATE FIRST TREATED FOR THIS CONDITION: _____

   IS CLAIM DUE TO AN ACCIDENT? ☐ NO ☐ YES IF YES, DATE OF ACCIDENT _____

   IF AN ACCIDENT, DID IT OCCUR AT: ☐ HOME ☐ WORK ☐ OTHER _____

   DESCRIBE HOW ACCIDENT HAPPENED: _____

   _____

   _____

6. **IF YOU INDICATED IN SECTION #5. OF THIS FORM THAT THE TREATMENT RECEIVED WAS DUE TO AN ACCIDENT, PLEASE COMPLETE SECTION #6 IN FULL. IF NECESSARY, USE A SEPARATE SHEET OF PAPER.**

TO DETERMINE WHETHER ANY THIRD PARTIES MAY ULTIMATELY BE HELD LIABLE FOR THE ACCIDENT, INJURY, OR ILLNESS, THE FOLLOWING INFORMATION IS REQUESTED:

A. WHERE DID THE ACCIDENT TAKE PLACE (INCLUDE NAME AND ADDRESS)?

_____

B. WHO OWNS THE PROPERTY WHERE THE ACCIDENT TOOK PLACE (INCLUDE NAME AND ADDRESS)?

_____

C. LIST ANY ATTORNEYS REPRESENTING THE PATIENT IN CONNECTION WITH THE ACCIDENT (INCLUDE NAMES, ADDRESSES, AND PHONE NUMBERS).

_____

D. LIST ANY INDIVIDUALS OR ENTITIES THAT MAY BE RESPONSIBLE FOR THE ACCIDENT (INCLUDE NAMES, ADDRESSES, AND PHONE NUMBERS).

_____

E. LIST ANY ATTORNEYS REPRESENTING ANYONE WHO MAY BE RESPOSIBLE FOR THE ACCIDENT (INCLUDE NAMES, ADDRESSES, AND PHONE NUMBERS).

_____

F. LIST ANY INSURANCE PROVIDERS WHO MAY BE LIABLE FOR THE ACCIDENT OR INJURY (INCLUDE COMPANY NAMES, ADDRESSES, AND POLICY NUMBERS). FOR EXAMPLE, IF THE INJURY ARISES FROM A CAR ACCIDENT, PROVIDE INFORMATION ABOUT THE AUTOMOBILE INSURANCE COMPANIES.

_____

G. WITH RESPECT TO THE ACCIDENT, LIST ANY LAWSUITS, OTHER LEGAL CLAIMS OR PROCEEDINGS, SETTLEMENT DISCUSSIONS OR SETTLEMENTS, OR ACTUAL OR POTENTIAL RECOVERIES FROM THIRD PARTIES.

_____

THE FUND OFFICE WILL REVIEW THIS INFORMATION. IF THE CLAIM IS APPROVED, YOU MAY BE REQUIRED TO SIGN AN "AGREEMENT OF REIMBURSEMENT" AND AN "AUTHORIZATION AND RELEASE" FORM. CONTACT THE FUND OFFICE IF YOU HAVE ANY QUESTIONS REGARDING THIS MATTER.

7. **THIS CLAIM FORM MAY ALSO BE USED TO SUBMIT A BILL FOR PROVIDERS WHO WILL NOT BILL BLUE CROSS BLUE SHIELD DIRECTLY; FOR SERVICES FOR WHICH YOU WERE REQUIRED TO PAY; AND/OR FOR INFERTILITY DRUGS. IF YOU ARE USING THIS FORM TO SUBMIT A BILL FOR PAYMENT, BE SURE TO ATTACH THE ITEMIZED BILL. IN ADDITION, IF APPLICABLE:**

1.) **ATTACH A PAID RECEIPT IN ORDER TO BE REIMBURSED DIRECTLY.**
2.) **ATTACH AN EXPLANATION OF BENEFITS FROM THE PRIMARY INSURANCE CARRIER TO SUBMIT A CLAIM FOR COORDINATION OF BENEFITS.**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for the services as described herein, but not to exceed the reasonable and customary charge for those services.

_____
SIGNATURE OF MEMBER DATE

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the Physician named herein to release any information acquired in the course of my examination or treatment.

_____
SIGNATURE OF MEMBER OR PARENT OF MINOR

_____
DATE

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE BILLS ATTACHED WERE INCURRED BY THE PATIENT LISTED ABOVE.

ANY PERSON WHO KNOWINGLY OR WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE **SHEET METAL WORKERS' LOCAL UNION #73 WELFARE FUND,** FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A **CRIMINAL ACT PUNISHABLE UNDER THE LAW.**

SIGN HERE: _____
SIGNATURE OF MEMBER DATE