

RETIREE

SHEET METAL WORKERS' HEALTH PLAN of Southern California, Arizona and Nevada

P.O. Box 10067
Manhattan Beach, CA 90266-8567
Phone: (310) 798-6572

**MEDICAL EXPENSE
CLAIM FORM**

**MAIL COMPLETED
FORM AND ALL
BILLS TO PLAN
OFFICE**

EMPLOYEE'S STATEMENT

Social Security Number	Name (Last Name first)	Local Union No.
Address: Street	City	State Zip
Phone		

Patient's Name	Male <input type="checkbox"/>	Date of Birth			If Dependent, relationship
Patient's Address	Female <input type="checkbox"/>	Month	Day	Year	
		Spouse's Occupation			

Is the Patient covered under any other group prepayment plan that provides benefits for this disability? Yes No If yes, is the entire cost paid by an employer? Yes No Does dependent child reside with you? Yes No If step-child does natural mother have Group Insurance? Yes No Is the Patient covered under Medicare? Yes No If yes effective date _____ and attach Medicare Explanation of Benefits.

Company Name (Spouse's Employer) _____

Spouse's Social Security No. _____

Name of Company providing benefit for Spouse _____ Policy No. _____

Address _____ Phone _____

Is disability due to patient's occupation? Yes No Employed by _____

If "Yes", has patient filed or does he intend to file a claim for Workmen's Compensation? Yes No

First full day unable to work _____ Date resumed work _____ Date expected to resume work _____

Is Patient's condition due to an accident? _____ if yes, when _____ 19____ P.M.
(Yes or No) _____ A.M.

DESCRIBE ACCIDENT AND HOW AND WHERE IT OCCURRED?

I hereby certify that the foregoing statements including any accompanying statements are true, correct and complete to the best of my knowledge and hereby authorize the attending physician or practitioner, and the hospital in which confinement took place, if any, to furnish and disclose all records and information concerning the patient's physical condition that are within their control or knowledge.

I further authorize, on behalf of myself and my dependent, if any, the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada to use or disclose any information contained in its file in whatever manner it deems necessary for the purpose of determining the reasonableness of any of the expenses submitted herewith or the propriety of this claim.

DATE SIGNED: _____ EMPLOYEE'S SIGNATURE _____

IMPORTANT

1. Employee must sign claim form.
2. Answer ALL questions on this statement. Do not return form until physician has completed reverse side.
3. If this claim is for a dependent, an enrollment card listing such dependent must be on file in the Plan Office before claim can be processed.
4. If payment is to be made to Physician, Employee must sign Authorization on reverse side.
5. The furnishing of this form is not an admission of liability by the Sheet Metal Workers's Health Plan of Southern California, Arizona and Nevada nor waiver of any of its rights or defenses.

I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada with information regarding benefits to which I/we may be entitled. (If claim for spouse, spouse must also sign.)

Date Dependent's signature Employee's signature

PHYSICIAN'S STATEMENT

Patient's Name (Last Name First)	Male <input type="checkbox"/>	Relationship to Employee	Age
	Female <input type="checkbox"/>		

Diagnosis (Describe Complications, if any) _____

Is Disability due to Patient's Occupation? Yes No If yes, Explain _____

Cause of disability _____ If Pregnancy, list date of _____
 Accident Sickness Pregnancy L.M.P. _____

If Accident, date of accident _____ How and Where did it occur, as indicated in your records? _____

SURGICAL SERVICES

Nature of Surgical or Obstetrical Procedure (describe in detail) R V S # _____	Date of Surgery
	Fee for Surgery

If Laceration, Number of Sutures () _____ If Fracture, Open Closed Simple Compound

NON-SURGICAL SERVICES

Date and Place					Describe each service (Examination, Treatment, X-ray, Etc.)	Fee Charged
Date	Home	Hospital	Office	RVS =		

If Hospitalized, Name of Hospital	Admission Date	Dismissal Date and Hour
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Date Patient returned to work _____ If Patient still disabled, approximate date of release for work: _____

Is Patient covered by any other Health Coverage? Yes No Give name, address and Policy Number of other carrier. _____

Is Patient entitled to Medicare (Yes No) (PART A) (Yes No) (PART B) _____

I hereby authorized the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada or its representatives to examine all medical records pertaining to the disability of the above-named patient.

DATE SIGNED _____ PHYSICIAN'S SIGNATURE _____

Address of Physician	Phone Number	Please Print or Type Physician's Name and Tax I.D. No.
	Area _____	Please Indicate Amount Paid
		\$ _____

EMPLOYEE'S AUTHORIZATION

The undersigned hereby authorizes Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada, to pay whatever medical or surgical benefits may be due the undersigned under the terms of the Medical Plan, (except Hospital) by check drawn to the order of the physician or surgeon indicated hereon to the extent of the physician's or surgeon's charges herein or by statement attached.

DATE SIGNED _____ EMPLOYEE'S SIGNATURE _____