FOX VALLEY LABORERS HEALTH AND WELFARE FUND

2371 Bowes Road, Suite 500, Elgin, Illinois 60123-5523
847-742-0900 • 866-828-0900 (toll free) • 847-742-4430 (fax)

MEDICAL CLAIM FORM

SECTION I - MEMBER'S STATEMENT and PATIENT INFORMATION *(see reverse side for instructions)*

1. MEMBER'S NAME — FIRST | MIDDLE INITIAL | LAST

2. Social Security Number _____ — _____ — _____

3. Mailing Address, Street, City, State, Zip Code

Tel. No. ( )

4. Local Union Number _____

Single | Married | Divorced

5. Patient Name: First | Middle Initial | Last

6. Relationship To Emp. Self | Spse | Dtr. | Son

7. Sex M | F

8. Patient Birth Date Mo. | Day | Yr.

9. Full time student ☐ Yes ☐ No

10. Handicapped Child ☐ Yes ☐ No

11. OTHER GROUP HEALTH INSURANCE COVERAGE — Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

12. WAS CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO

B. AN AUTO ACCIDENT ☐ YES ☐ NO

13. DATE OF ACCIDENT _____

PLACE OF ACCIDENT _____

DESCRIPTION OF ACCIDENT _____

14. Onset Date of Illness _____

15. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF MEDICAL TREATMENT.

SIGNED PATIENT or PARENT IF MINOR. | DATE

16. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED SERVICE PROVIDER; THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

MEMBER'S SIGNATURE | DATE

SECTION II - ATTENDING PHYSICIAN'S STATEMENT

17. DATE OF ILLNESS (FIRST SYMPTOM) or INJURY (ACCIDENT) or PREGNANCY (LMP)

18. DATE FIRST CONSULTED PHYSICIAN FOR THIS CONDITION

19. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? Yes | No

20. IF AN EMERGENCY, CHECK HERE ☐

21. DATE PATIENT ABLE TO RETURN TO WORK

22. DATES OF TOTAL DISABILITY — MEMBER ONLY — FROM | THROUGH | DATE LAST WORKED

23. WAS SURGERY PERFORMED? DATE

24. NAME OF REFERRING PHYSICIAN

25. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED | DISCHARGED

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

27. 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 TO NUMBERS 1, 2, 3, ETC. OR DC CODE

A DATE OF SERVICE	B* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE CPT-4	(EXPLAIN UNUSUAL SERVICE OR CIRCUMSTANCES)	D DIAGNOSIS ICD-10-CM	F CHARGES	G DAYS OR UNITS

28. PHYSICIAN'S SIGNATURE | DATE

29. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY SEE BACK) YES ☐ ☐ NO

30. TOTAL CHARGES

31. AMOUNT PAID

32. BALANCE

33. YOUR PATIENT'S ACCOUNT NO.

34. YOUR PROVIDER ID. NO.

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

INSTRUCTIONS FOR MEMBER

Please be sure that you complete ALL of the information in Section I on the front of this form.

NOTE:

BOX 11 - If you or the patient is covered by any other group insurance policy, please provide us with the name of the insurance company, address and policy number(s).

BOX 12 - Please be sure to check either yes or no to parts A and B.

BOX 13 - If the patient's treatment is the result of an accident, please provide us with the date of the accident, place of the accident and a description of the accident.

BOX 15 - Please be sure to sign this box for the release of any information.

BOX 16 - Only sign this box if you want benefits paid directly to the provider. Do not sign this box if you want benefits paid to you.