Plumbers & Steamfitters Local 248

Medical Claim Form

Claims Administrator:
230 Lexington Green Circle, Ste 400
Lexington, KY 40503-3319
1-888-999-7741

Please answer all questions fully. This will help to avoid unnecessary correspondence.

SECTION I	**TO BE COMPLETED BY EMPLOYEE**			
1	Name of Employee **Last** **First** **Middle**			
2	Social Security #:	☐ Married ☐ Single	**Sex:** M F Birthdate:	Phone Number:
3	Address of Employee Number & Street City State Zip			
4	If Married, Spouse's First Name: Is Spouse Employed? ☐ **Yes** ☐ **No**		If "Yes" Name & Address of Spouse's Employer:	
5	Have you (or your Dependent) visited a Doctor or taken Prescription Medicine for this condition before dates shown by your Doctor on this Form? ☐ **YES** ☐ **NO**		If "YES," Name & Address of Doctor: Date(s) of Treatment:	
6	Are Benefits Payable from another source for the expenses submitted? ☐ **YES** ☐ **NO**		If "YES" Insurance Company Employer Policy No. or ID No.	
7	If Hospital confined check type of Room ☐ **PRIVATE** ☐ **SEMI-PRIVATE** ☐ **WARD**			
8	Is Condition due to an Accident? ☐ **YES** ☐ **NO**	If "YES" Check: ☐**Auto Accident** ☐**Other** If "OTHER" please describe:	Did Accident happen while working? ☐ **YES** ☐ **NO**	Date of Accident:

To be Completed by Employer if Time Loss Involved (please use typewriter)			
First full day unable to work:	Date returned to work	Date expected to return to work	Name of Employer
Is there any possibility this disability was caused by employment? ☐ **YES** ☐ **NO**		If "YES," explain:	
Date	**Signed**		**Title**

Claimant's Signature		
11	Employer _____ Date	AUTHORIZATION: I HEREBY AUTHORIZE RELEASE TO OR BY UMR, OF ANY HOSPITAL, MEDICAL OR BENEFIT INFORMATION CONCERNING MYSELF OR ANY OF MY DEPENDENTS WHICH MAY BE REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED. _____ Employee's Signature

Instructions
THIS FORM MUST BE COMPLETED BY THE EMPLOYEE AND HIS PHYSICIAN. BE SURE THAT ALL QUESTIONS ARE ANSWERED IN SECTION I. UNANSWERED QUESTIONS WILL DELAY BENEFIT CONSIDERATION UNTIL THE MISSING INFORMATION IS OBTAINED. ATTACH ITEMIZED BILLS FOR COVERED MEDICAL EXPENSES NOT SHOWN IN SECTION II. DON'T SEND CANCELLED CHECKS. CASH REGISTER RECEIPTS, OR LISTS PREPARED BY CLAIMANT. THE ACTUAL BILLS ARE NEEDED. DRUG STORE BILLS MUST SHOW THE PRESCRIPTION NUMBER AND NAME OF PRESCRIPTION DRUG(S).

Section II	**Attending Physician's Statement**

Read instructions before completing or signing this form

Note: Return completed form to the Employee or Employer

☐ **MEDICARE** ☐ **MEDICAID** ☐ **CHAMPUS** ☐ **OTHER**

PATIENT & EMPLOYEE INFORMAITON — **Type or Print Form**

1. Patient's Name (First, Middle Initial, Last)	2. Patient's Date of Birth	3. Employee's Name (First, Middle Initial, Last)
4. Patient's Address (Street, City, State, Zip)	5. Patient's Sex: **M F** 6. Patient's Relationship to Employee ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	7. Employee's Social Security No. or Medicare No. (include any letters) _____ 8. Employee's Plan No.
9. Other Health Coverage-Enter Name of Policyholder, Plan Name, Address & Policy or Medical Assistance Number. _____	10. Was condition related to: A. Patients Employment ☐ **YES** ☐ **NO** B. An Auto Accident ☐ **YES** ☐ **NO**	11. Employee's Address (street, city, state, zip)
12. **PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE** (I Authorize the Release of any Medical Information Necessary to Process this Claim.) **Signed:**_____ **Date:**_____		13. **I Authorize Payment of Medical Benefits to Undersigned. Physician or supplier for Services Described Below.** _____ **Signed** (Employee)

PHYSICIAN OR SUPPLIER INFORMATION

14. Date of: Illness (1st symptom) or _____ Injury or _____ Pregnancy (LMP) _____	15. Date First Consulted you for this condition?	16. Has Patient ever had same or similar symptoms? ☐ **YES** ☐ **NO**
17. Date Patient able to return to work?	19. Dates of Total Disability **From:**_____ **Through**_____	19. Date Last Seen?_____
20. Name of Referring Physician?	21. For services related to hospitalization give Hospitalization Dates: **Admitted:**_____ **Discharged:**_____	
22. Name & Address of Facility where Services Rendered (if other than home or office)	23. Was Laboratory work performed outside your office? ☐ **YES** ☐ **NO CHARGES**	

Diagnosis or Nature of Illness or Injury (Relate Diagnosis to Procedure in Column D by Reference to Numbers 1,2,3, etc or Dx Code)

1.
2.
3.
4.

24. **A** **Date of Service**	**B** **Place of Service**	**C** **Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given (explain unusual services or circumstances)**	**D** **Diagnosis**

24. Signature of Physician or Supplier (Read before Signing) _____ Signed Date	25. **Printed Name of Physician or Supplier** (as signed in #24)	26. Your Social Security # _____ 27. Your Employer ID #
28. Physician's or Suppliers (Name, Address, Zip & Telephone Number)		29. Your Patient's Account Number

Place of Service Codes:

1 - (H) – Inpatient Hospital	4 – (H) – Patient's Home	7 – (NH) – Nursing Home	O – (OL) Other Location
2 – (OH) – Outpatient Hospital	5 – ( ) – Day Care Fac (PSY)	8 – (SNF) – Skilled Nursing Fac	A – (IL) Independent Lab
3 – (O) – Doctor's Office	6 – ( ) – Night Care Fac (PSY)	9 – Ambulance	B – Other Med/Surgical Fac