

**STATEMENT OF CLAIM  
(GROUP HEALTH INSURANCE)**

**DISABILITY FORM**

RETURN THE FORM PROMPTLY TO **Teamsters 170**  
P.O. Box 1046, Worcester, MA 01613

Claim Registration No. \_\_\_\_\_

For Claim Office Use Only  
PD  PND  PP  DENY  Date \_\_\_\_\_

Examiner \_\_\_\_\_

**INSTRUCTIONS**

**EMPLOYEE: PLEASE FILL OUT & SIGN THE EMPLOYEE'S STATEMENT, AND THE AUTHORIZATION TO OBTAIN INFORMATION. IF YOU WISH TO AUTHORIZE RELEASE OF MEDICAL INFORMATION AND/OR ASSIGN BENEFITS, PLEASE SIGN WHERE INDICATED IN QUESTIONS 12 & 13 ON REVERSE SIDE. (IMPORTANT: FAILURE TO FULLY ANSWER ALL QUESTIONS MAY DELAY THE PROCESSING OF YOUR CLAIM. HAVE YOUR DOCTOR COMPLETE THE "HEALTH INSURANCE CLAIM FORM" ON THE REVERSE SIDE AND RETURN THE FORM PROMPTLY TO YOUR EMPLOYER AT THE PROPER ADDRESS. IF YOU SUBMIT BILLS FOR COVERED SERVICES NOT REPORTED ON THE "HEALTH INSURANCE CLAIM FORM" EACH BILL MUST DESCRIBE NAME OF PATIENT, DIAGNOSIS, NATURE OF SERVICES OR SUPPLIES FURNISHED, AS WELL AS THE DATE AND AMOUNT OF EACH**

**EMPLOYEE'S STATEMENT**

1. Employee's Name		2. Date of Birth		3. Sex		4.		5. Policy No.	
Employee Address Street		Mo.	Day	Year	M	F	<input type="checkbox"/> Single	<input type="checkbox"/> Legally Separated	Firm No.
City State Zip							<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
								Acct. No.	

6. Is Your Spouse Employed?  Yes  No If "Yes" Give Name of Spouse \_\_\_\_\_ Name and Address of Spouse's Employer \_\_\_\_\_

7. If Claim is for a Dependent, Please Complete: Name of Dependent \_\_\_\_\_ Date of Birth Mo. Day Year  Married  Single Relationship of Dependent  Wife  Husband  Son  Daughter  Stepchild If Stepchild, Do you claim the Child for Federal Income Tax?  Yes  No






8. If Claim is for a Dependent Child Over 18, is Dependent a Full-Time Student?  Yes  No If "Yes", Where \_\_\_\_\_ If Dependent Child is Employed, Give Name and Address of Employer \_\_\_\_\_

9. Nature of Illness or Injury \_\_\_\_\_ Date of First Treatment \_\_\_\_\_ 10. If Condition is Due to an Accident Please State: \_\_\_\_\_ Where it Happened \_\_\_\_\_

When Accident Happened Date \_\_\_\_\_ Time \_\_\_\_\_ How Accident Happened \_\_\_\_\_

11. Is Claim Likely to Come Under Worker's Compensation?  Yes  No 12. Give Name and Address of All Physicians Treating Patient: \_\_\_\_\_

13. Are you or your Dependents Entitled To Benefits Under Any Other Employer, Union, Student Association, Group Plan, Group Blue Cross, Blue Shield, Medicare, Medicaid or any other Governmental Program?  Yes  No (If "Yes" Please Attach Copies of Statements of Benefits Paid or Denied and Complete The Following:

Person Carrying Other Insurance (Coverage) 	Plan or Policy No./Certificate or Blue Cross No.
Effective Date of Insurance Coverage 	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Employee/Subscriber Social Security Number 	Employee/Subscriber Birthdate
Employer or Sponsoring Organization 	Address
Insurance Company 	Address of Local Claim Office

**AUTHORIZATION TO OBTAIN INFORMATION**

To all physicians; medical professionals; hospitals; clinics; other health care providers; insurers; employers; group policyholders; insurance support organizations; and other persons who have information about the patient.


I authorize you to give Local 170, its reinsurers or its agents: (a) all information you have as to illness, injury, medical history, diagnosis, treatment and prognosis with respect to any physical or mental condition of the patient; (b) all employment information you have about the patient; and (c) any other information you have about the patient which Local 170 believes it needs to perform the functions described below.

The information obtained will be used: (a) to determine if the patient is eligible for benefits under a Local 170 contract; and (b) for any other purpose which relates to the contract.

This form will be valid for as long as the claim lasts. I know that I may request a copy of it. I agree that a photocopy is as valid as the original.

**FRAUD STATEMENT REQUIRED BY SOME STATES**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.**

Signature of Employee 	Social Security No.	Signed Patient (If other than employee) or Parent if Minor	Date
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**FUND OFFICE**

THE FUND OFFICE WILL COMPLETE THE EMPLOYER'S STATEMENT AFTER THE EMPLOYEE'S STATEMENT AND THE DOCTOR HAS COMPLETED THE "HEALTH INSURANCE CLAIM FORM". THEN SUBMIT THIS FORM TO THE STATE MUTUAL CLAIM OFFICE SERVICING YOUR ACCOUNT. ITEMS 3, 4, AND 15 MUST BE COMPLETED IF CLAIM INVOLVES WEEKLY DISABILITY INCOME INSURANCE.

1. Name of Employee		2. Occupation		3. Ave. Weekly Wage		4. Weekly Benefits		5. Policy Number		6. Account Number	
7. Deductible		8. Date Employment Commenced		9. Effective Date of Insurance Coverage				10. Date Last Worked		11. Date Returned to Work	
		Employee		Dependent							
12. Reason for Leaving Work <input type="checkbox"/> Termination <input type="checkbox"/> Layoff <input type="checkbox"/> Retired <input type="checkbox"/> Disability								13. Give Date if Insurance has Terminated			
								Employee		Dependent	

Employer's Name & Address Return the Form Promptly to <b>Teamsters 170 Health &amp; Welfare Fund P.O. Box 1046 Worcester, MA 01613</b>		Is Your Company Required to Pay FICA Taxes? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes" What % of Premium Does Your Co. Pay For This EE <u>100</u> %	
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BY (AUTHORIZED REPRESENTATIVE'S SIGNATURE)		DATE	
TITLE			

# HEALTH INSURANCE CLAIM FORM

Dear Doctor: After you have completed and signed this form please return it to The Fund Office as soon as possible.

## PATIENT & INSURED INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH 	3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. PATIENT'S SEX MALE <input type="checkbox"/> <input type="checkbox"/> FEMALE	6. INSURED'S I.D. No. or MEDICARE No. (include any letters)
	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. INSURED'S GROUP NO. (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> <input type="checkbox"/> NO B. AN AUTO ACCIDENT YES <input type="checkbox"/> <input type="checkbox"/> NO	11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) <i>I Authorize the Release of any Medical Information Necessary to Process this Claim.</i>	SIGNED _____ DATE _____	13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW  SIGNED (Insured or Authorized Person) _____

## PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> <input type="checkbox"/> NO
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____
19. NAME OF REFERRING PHYSICIAN		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> <input type="checkbox"/> NO CHARGES	

23. 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 PROCEDURE CODE (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing)	26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> <input type="checkbox"/> NO	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNED _____ DATE _____	30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.	I. NO.		

\*PLACE OF SERVICE CODES

1 - (IH) - INPATIENT HOSPITAL	4 - (H) - PATIENT'S HOME	7 - (NH) - NURSING HOME	O - (OL) - OTHER LOCATIONS
2 - (OH) - OUTPATIENT HOSPITAL	5 - DAY CARE FACILITY (PSY)	8 - (SNF) - SKILLED NURSING FACILITY	A - (IL) - INDEPENDENT LABORATORY
3 - (O) - DOCTOR'S OFFICE	6 - NIGHT CARE FACILITY (PSY)	9 - AMBULANCE	B - OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

**ATTENDING PHYSICIAN'S  
SUPPLEMENTARY STATEMENT**TEAMSTERS LOCAL 170  
HEALTH AND WELFARE FUND  
PO BOX 1046  
WORCESTER, MA 01613

Tel: (508) 791-3416

1. PATIENT'S NAME	AGE	CLAIM NO.	GROUP NO.
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2. NATURE OF SICKNESS OR INJURY (describe complications, if any)

3. NATURE OF TREATMENT (including surgery and medications prescribed, if any)

4. OBJECTIVE FINDINGS (including current X-rays, EKG's, laboratory data and any clinical findings)

## 5. DATES OF TREATMENT

a. Date of first visit \_\_\_\_\_  
MONTH / DAY / YEARb. Date of last visit \_\_\_\_\_  
MONTH / DAY / YEARc. Frequency:  Weekly  Monthly  Other (specify): \_\_\_\_\_

## 6. PROGRESS

a. Patient has:  Recovered  Improved  Unchanged  Retrogressedb. Patient is:  Ambulatory  House confined  Bed confined  Hospital confined

## 7. DISABILITY STATUS

A. At the time of your last exam was the patient able to return to work?  YES  NOB. If presently disabled (unable to work), please indicate the date patient will be able to return to work: \_\_\_\_\_  
MONTH / DAY / YEARC. Patient has been totally and continuously disabled from \_\_\_\_\_ through \_\_\_\_\_  
MONTH / DAY / YEAR MONTH / DAY / YEAR

## 8. REMARKS

9. NAME OF ATTENDING PHYSICIAN (Please print or type)	SIGNATURE	DATE
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## 10. ADDRESS

No. &amp; Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No.: ( ) \_\_\_\_\_

**TO AVOID DELAYS IN PROCESSING COMPLETE IN FULL AND MAIL TO ABOVE ADDRESS**