CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

IMPORTANT: To assure payment of Benefits, this form should be FULLY COMPLETED and submitted to the Claim Settlement Office IMMEDIATELY following injury or commencement of treatment.

PO BOX 2280, OAKLAND, CA 94621
(888) 547-2054 or
(510) 633-0333

Read instructions on back before completing form.
TYPE OR PRINT

CHECK IF YOUR ADDRESS HAS CHANGED SINCE YOUR LAST CLAIM ☐

STATEMENT OF MEDICAL CLAIM

PART I PATIENT & PLAN MEMBER (EMPLOYEE) INFORMATION

1. Employee's Name (First, Middle, Last Name)	2. Address (Street) (City) (State) (Zip Code)			
3. Name of Company Where You Work and Date of Hire	4. Employee's Social Security Number	5. Union Local No.	6. Employee's Date of Birth	7. Home Phone Number ( ) (Area Code Number)

8. Patient's Name	9. Patient's Date of Birth	10. Patient's Sex ☐ Male ☐ Female	11. Patient's Address (Street) (City) (State) (Zip Code)

12. Patient's Relationship To Employee	13. If patient not member, list patient occupation and Name of Employer	14. MUST BE ANSWERED IF PATIENT INJURED A. Date of Injury B. Where did the injury occur? C. How did the injury occur?
15. Was Illness or Injury Work Related Yes ☐ No ☐		

16. Is Any Member of Your Family Covered by any Other Health Insurance, Group Plan, Medicare or Other Government Plan? Yes ☐ No ☐ If Answer is Yes, complete questions 16a through 16g. If Answer is No, proceed to No. 17.

16a. Please provide name and address of OTHER Plan or Group:	16b. Group No. or Policy No.	16c. PLAN TYPE Active ☐ Retiree ☐
16d. Name of Employer or Organization Providing Other Coverage:	16e. Name of Primary Person Covered Under Other Plan:	16f. Identifying No./SS No. of Primary Person Covered Under Other Plan	16g. Primary Person's Date of Birth

17. I AUTHORIZE ANY MEDICAL INFORMATION RELATING TO THIS CLAIM TO BE DISCLOSED TO AND ACQUIRED BY THE ADMINISTRATOR OF THIS PLAN AND SUCH AGENTS OF THE ADMINISTRATOR AS ARE NECESSARY TO PROCESS THIS CLAIM. SUCH INFORMATION MAY BE DISCLOSED BY A HEALTH CARE PROVIDER OR OTHER PLAN ADMINISTRATOR, AND WILL BE USED FOR THE PURPOSE OF PROCESSING THIS CLAIM. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL THE CLAIM IS PAID, PROVIDED, SUCH INFORMATION SHALL BE RETAINED BY THE ADMINISTRATOR IF REQUIRED BY LAW.

Patient's Signature (Parent or Guardian's Signature, if Patient is a minor).

X _____

Upon request, the patient shall be furnished with a copy of this authorization.

18. EMPLOYEE'S SIGNATURE (I hereby certify that the foregoing statements including any accompanying statements are to the best of my knowledge and belief true and correct. **CHECK: ✓ I DO ☐ I DO NOT ☐** authorize the administrator, in his sole discretion, to pay directly to the below named physician or any other supplier of services, any benefits otherwise payable to me, but not to exceed any of the charges by the physician or other supplier of services. I understand that I am financially responsible for any charges not covered by this authorization.)

X _____ DATE _____

PART II PHYSICIAN OR SUPPLIER INFORMATION

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER—OR YOU MAY ATTACH AN ITEMIZED BILL INCLUDING DIAGNOSIS

19. DATE OF: ☐ ILLNESS (FIRST SYMPTOM) OR ☐ INJURY (ACCIDENT) OR ☐ PREGNANCY (LMP)	20. DATE FIRST CONSULTED YOU FOR THIS CONDITION	21. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐	WORK RELATED? YES ☐ NO ☐

22. DATE PATIENT ABLE TO RETURN TO WORK	23. DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM	THROUGH

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 ☐ CHARGES:	

28. 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.

29. 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

30. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE		31. TOTAL CHARGE	32. AMOUNT PAID	33. BALANCE DUE
	34. YOUR SOCIAL SECURITY NO.	35. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
36. YOUR PATIENT'S ACCOUNT NO.	37. YOUR EMPLOYER I.D. NO.	LICENSE NO.		

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