Sheet Metal Workers Local #22 Welfare Fund
106 South Avenue, West
Cranford, NJ 07016

MEDICAL CLAIM FORM

Member's Name (print in full)	Policy or Plan No.	Social Security Number
	C-9284	☐☐☐ — ☐☐ — ☐☐☐☐
Home Address	Date of Birth	Daytime Phone Number
	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed	Work Status: ☐ Active ☐ Disabled ☐ Retired ☐ Other (specify)
City State ZIP		

PATIENT INFORMATION

Name	Date of Birth
Soc. Sec. No.	

Relationship to Member: ☐ Self ☐ Spouse ☐ Child* ☐ Other (specify)

Sex: ☐ Male ☐ Female

*If Child: Married? ☐ Yes ☐ No Full-time Student? ☐ Yes ☐ No

Medicare Coverage — Effective Date

☐ Hospital (Part A) only ☐ Both (A&B)
☐ Medical (Part B) only ☐ None

SPOUSE INFORMATION

Name	Date of Birth

Social Security Number: ☐☐☐ — ☐☐ — ☐☐☐☐

Employment Status: ☐ Active ☐ Retired ☐ Not Employed

Employer Name and Address

Describe sickness or injury. If injury, where and how did it occur?

Date sickness began or injury occurred	Did injury occur at work? Was sickness caused by work? ☐ Yes ☐ No	Was injury caused by an automobile accident? If yes, specify city & state above. ☐ Yes ☐ No

IF YOU OR ANY MEMBER OF YOUR FAMILY IS COVERED UNDER ANOTHER GROUP HEALTH PLAN, COMPLETE THE FOLLOWING SECTION.

Covered Family Member
☐ Self ☐ Patient
☐ Spouse ☐ Other: specify Name and Relationship

Policy or Plan No.	Insurance ID Number	Type of Coverage ☐ Individual ☐ Family

Name and Address of Insurance Company

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY 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.

AUTHORIZATION FOR RELEASE OF INFORMATION: I/We authorize the release to Sheet Metal Workers and its agents of any evidence or information about me or my dependents that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original. (Patient's signature is required if patient is a legal adult.)

Member's Signature _____ Date _____ Patient's Signature _____ Date _____

INSTRUCTIONS FOR MAKING CLAIM FOR BENEFITS
1. Answer all required questions on this side of form, and sign it.
2. If you want us to pay the hospital or doctor directly, sign the "Assignment of Benefits" section on the reverse.
3. Have the doctor complete his section or attach an itemized bill indicating the patient's name, diagnosis, the type, place and date of each service, and the amount charged.

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THIS SECTION TO BE COMPLETED BY POLICYHOLDER

Member Effective Date	Member Termination Date

I certify that the patient named in this claim was eligible for medical benefits during the period specified above.

Policyholder's Representative _____ Date _____

EMPLOYER/DISABILITY INFORMATION

1. From what date was he continuously employed?
2. On what date did he last work prior to his disability? Wkly. Wage $
3. Is this disability the result of injury or occupational disease arising out of or in the course of employment?
4. If the cause of disability was occupational, has it been reported to the state board of commission or to any insurance company as a workmen's compensation claim?

If not, please state the reasons:

5. If the employee has returned to work, please indicate exact date

Name of employer

Employer's tax I.D. number By

Address of employer

ASSIGNMENT OF BENEFITS	I authorize payment of benefits to the undersigned physician or supplier for the services described below. Member's Signature Date

PHYSICIAN OR SUPPLIER INFORMATION: These sections to be completed by physician unless claim is submitted with an itemized bill.

Patient's Name (print in full)

Date of illness (first symptoms) Injury (accident), or Pregnancy (LMP)

Date first consulted for this condition

Has patient ever had similar symptoms? ☐ Yes ☐ No If Yes, When?

Referring Physician

Facility where services were rendered (if other than home or office)

IF PATIENT IS/WAS UNABLE TO WORK:

Date patient able to return to work

Dates of total disability from through

Dates of partial disability from through

ICDA CODES AND DESCRIPTIONS OF DIAGNOSES: Relate to services below with numbers at left

1. _____
2. _____
3. _____

HOSPITALIZATION: Use UB-82 codes.

Admission Date	Type Code	Source Code

Discharge Date	Discharge Status Code

▼	PLACE OF SERVICE*	PROCEDURE (CPT/RVS)	DESCRIPTION OF PROCEDURE, SERVICE, OR SUPPLY FURNISHED Explain unusual services or circumstances	DATES OF SERVICE From To	DAYS/ UNITS	CHARGES

Physician's or Supplier's Name, Address, and Telephone Number (print)

Patient's Account Number

Physician's Tax ID Number

Total Charges

Amount Paid

Balance Due

SMW #22 WILL NOT ACCEPT AN ASSIGNMENT OF BENEFITS WITHOUT THE PHYSICIAN'S OR SUPPLIER'S TAX IDENTIFICATION NUMBER

*PLACE OF SERVICE CODES

(1) Inpatient Hospital	(5) Day Care Facility	(9) Ambulance
(2) Outpatient Hospital	(6) Night Care Facility	(10) Other Locations
(3) Doctor's Office	(7) Nursing Home	(11) Independent Laboratory
(4) Patient's Home	(8) Skilled Nursing Facility	(12) Non-Hospital Surgical Ctr.

Physician's Signature Date