FOX VALLEY LABORERS HEALTH AND WELFARE FUND

2400 BIG TIMBER ROAD, BUILDING B, SUITE 206, ELGIN, ILLINOIS 60124-7812

(847) 742-0900

MEDICAL CLAIM FORM

SECTION I - MEMBER'S STATEMENT and PATIENT INFORMATION

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 CHARGES

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 ICD9CM	F CHARGES

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 EMPLOYER 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 14 - If the patient's treatment was for an emergency illness, please indicate the onset date of this illness.

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.