BAY AREA ROOFERS HEALTH & WELFARE TRUST FUND

United Administrative Services
P.O. Box 5057
San Jose, CA 95150

INSTRUCTIONS FOR FILING CLAIM
1. Employee complete this side of form.
2. Have attending physician complete the reverse side.
3. Attach itemized bills.
4. Send the completed form and bills to the address given.

STATEMENT OF CLAIM
FOR
GROUP BENEFITS

TO BE COMPLETED BY INSURED EMPLOYEE

ANSWER ALL QUESTIONS THAT APPLY.
SIGN WHERE INDICATED BY

EMPLOYEE IDENTIFICATION

Name ______ (First / Middle / Last) Marital Status ______

SS No. ______ Date of Birth ______

Address ______ (Street / City / State / ZIP)

DEPENDENT IDENTIFICATION (Complete only if claim is for dependent)

Dependent's Name ______ Date of Birth ______

Relationship ______ Marital Status ______

EMPLOYMENT INFORMATION

Employer's name BAY AREA ROOFERS H&W TRUST

Date Employed ______ Occupation ______

Do you have any other employer? ☐ Yes ☐ No If "Yes," complete below.

Name of Employer ______ Address of Employer ______

Is your spouse or any other of your dependents employed? ☐ Yes ☐ No If "Yes," complete below. Spouse's Date of Birth ______

Dependent's Name | Relationship | Name and Address of Employer

Are any hospital, surgical or medical benefits or services provided under any group, blanket, school, franchise or No Fault auto insurance plan, or under any state, federal or other governmental program? ☐ Yes ☐ No

Name and address of the insurance company or other organization providing benefits and the policy numbers

Was the claimant covered under any group health plan in effect immediately prior to the date he or she became covered under the policy, with no gap in coverage? ☐ Yes ☐ No

If "Yes," please provide: (1) the name and address of the insurance company or other organization providing the benefits; (2) the policy numbers; and (3) the date the claimant's coverage was effective.

Are you or your spouse or any child covered under Social Security (Medicare) Health Insurance? ☐ Yes ☐ No

If "Yes," indicate your coverage by checking appropriate box at the right.

Hospital Only (PART A)	Medical Only (PART B)	Hospital and Medical
☐ Self	☐ Self	☐ Self
☐ Spouse	☐ Spouse	☐ Spouse
☐ Child	☐ Child	☐ Child

CLAIM INFORMATION

Describe Sickness/Accident Suffered ______

Date Sickness Began/Date-Time of Accident ______ (Mo. Day Yr)

Hour ______ ☐ a.m. ☐ p.m.

Was accident or sickness work related? ☐ Yes ☐ No

First day unable to work ______ (Date / Hour)

Date returned to work ______ (Date)

If claim is for a dependent child over 18 years old, is the child:
(a) dependent on you for support? ☐ Yes ☐ No
(b) a full-time student? ☐ Yes ☐ No
(1) Give number of enrolled credit hours ______
(2) Name and address of school ______

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

AUTHORIZATION TO RELEASE CLAIM INFORMATION
TO THE BAY AREA ROOFERS HEALTH & WELFARE TRUST FUND

To Any: Physician, hospital, pharmacist or other provider of health care services; insurer; employer; group policyholder; government agency; consumer reporting agency; acquaintance; policy or benefit plan administrator:

You may give the Bay Area Roofers Health & Welfare Trust Fund information about ______ (Claimant's Name) health, work status or health coverage.

You may also give this information on the Bay Area Roofers Health & Welfare Trust Fund's behalf to: (a) the claim investigation department of a consumer reporting agency; or (b) the claim department of a policy or benefit plan administrator. Health information means all information about: (a) a physical or mental health condition; (b) medical treatment and supplies; and (c) drug or alcohol use, if needed to evaluate my claim.

This information will be used to evaluate my claim for benefits. This form will be valid for the duration of my claim. A photocopy of this form is as valid as the original. I will receive a copy of this form if I ask for one in writing.

Date ______ Signature of Claimant (if not a minor) ______

Date ______ Signature of Insured ______

Employer BAY AREA ROOFERS H&W TRUST

Opposite side is for attending physician's statement.

TRUST FUND USE ONLY

Cert. No. ______ Class ______ Eff. date employee ______ Eff. date dep. ______ Term date ______

HEALTH INSURANCE CLAIM FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

PATIENT & INSURED (SUBSCRIBER) 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 ☐ ☐ FEMALE	6. INSURED'S I.D. No. or **MEDICARE No.** *(include any letters)*
	7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	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 ☐ ☐ NO B. AN AUTO ACCIDENT YES ☐ ☐ NO	11. INSURED'S ADDRESS *(Street, city, state, ZIP code)*
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below* *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 ☐ ☐ 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 ☐ ☐ 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 SIGNED DATE	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES ☐ ☐ NO	27. TOTAL CHARGE	28. AMOUNT PAID / 29. BALANCE DUE
	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.D. 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

BAR-CLAIM