# ARIZONA SHEET METAL TRUST FUNDS

## SSA MEXICO PPO NETWORK

2400 W. Dunlap Ave., Suite 250 * Phoenix, AZ 85021 * Phone 602-249-3582 * Toll Free 1-800-474-3485 * Fax 602-249-3795
www.southwestservicetpa.com

## PART A EMPLOYEE'S STATEMENT MUST BE COMPLETED BY EMPLOYEE PLEASE PRINT

| 1. EMPLOYEE NAME | 2. BIRTH DATE MO. DAY YR. | 3. ID# |
|---|---|---|
| 4. ADDRESS ☐CHECK HERE IF NEW ADDRESS CITY STATE ZIP | | 5. PHONE NO. |
| 6. CLAIM IS FOR ☐ SELF ☐ SPOUSE ☐ CHILD | 7. DEPENDENT'S NAME / 8. RELATIONSHIP | 9. BIRTH DATE MO. DAY YR. |
| 10. IS THIS CLAIM FOR AN ACCIDENT? ☐ YES ☐ NO | 11. IF YES - WHERE DID IT HAPPEN? / 12. WHEN? MO. DAY YR. | 13. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB? ☐ YES ☐ NO |

14. **EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION:**

I hereby certify that the foregoing statements, including any acccompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form.

I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form.

**Employee Signature: X** _____ **Date** _____
CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE MO. DAY YR.

## PART B PROVIDER'S STATEMENT MUST BE COMPLETED BY PROVIDER MEDICAL FORM

| 1. PATIENT'S NAME | 2. AGE | 3. SEX |
|---|---|---|
| | | |

4. DIAGNOSIS OR NATURE OF DISEASE, INJURY CLAIM OR VISION DISORDER

5. OCCUPATIONAL INJURY ☐YES ☐NO

| 6. DATE OF SERVICE MO. | DAY | YR. | PLACE OF SERVICE | PROCEDURE CODE CPT OR ADA CODES | LIST SEPARATELY: SERVICES, MATERIALS AND FITTINGS | CHARGES |
|---|---|---|---|---|---|---|
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| NOTE: Provider ID No. (No. 7) Must Be Completed | 7. PROVIDER ID NO. | 8. TELEPHONE NO. | 9. DATE | TOTAL CHARGES |
|---|---|---|---|---|
| 10. PROVIDER'S NAME AND DEGREE (PRINT) | 11. SIGNATURE X | | | AMOUNT PAID |
| 12. ADDRESS | 13. CITY | 14. STATE | 15. ZIP | BALANCE DUE |



**QUESTIONS? PHONE (602) 249-3582 TOLL FREE 1-800-474-3485 SE HABLA ESPAÑOL**