SMWIA LOCAL 49 FAMILY HEALTH PLAN

Administrative Office
2400 West Dunlap Avenue, Suite 250
Phoenix, Arizona 85021
Phone (505) 265-8422 Toll Free (800) 432-6636 Fax (505) 266-9358

BENEFIT CLAIM FORM (#049-15)

Instructions - Read the "How to Obtain Benefits" section of your Plan Booklet

Use this form to apply for Plan Benefits. (NOTE: Was your condition cased by an on-the-job injury or illness? If so - do not complete this form, instead, contact your employer who will assist you in filing your Worker's Compensation claim.)

INSTRUCTIONS - Is the claim for disability benefits ( ) YES ( ) NO

1. Employee must complete Part A.
2. Have your doctor complete Part B. (Your doctor's own itemized statement form may be substituted if it contains all of the needed information.)
3. **HAVE YOUR EMPLOYER COMPLETE PART C ONLY IF YOU ARE FILING FOR DISABILITY BENEFITS.**
4. Please check box if new address ☐

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

NOTE: THE FUND CANNOT PROCESS THE SUBMITTED CHARGES WITHOUT THIS CLAIM FORM COMPLETED IN FULL.

1. EMPLOYEE NAME (PLEASE PRINT)
2. BIRTHDATE MO. DAY YR.
3. SOCIAL SECURITY NO.
4. ADDRESS CITY STATE ZIP
5. PHONE NO. ( )
6. EMPLOYER
7. ADDRESS
8. PHONE NO. ( )
9. SPOUSE'S NAME
10. SPOUSE'S EMPLOYER
11. PHONE NO. ( )
12. CLAIM IS FOR ☐ SELF ☐ SPOUSE ☐ CHILD
13. PATIENT'S NAME (Include Last Name)
13A. RELATIONSHIP
14. BIRTHDATE MO. DAY YR.
15. DOES DEPENDENT LIVE WITH YOU? ☐ YES ☐ NO
16. IF NO: ADDRESS CITY STATE ZIP
17. IS DEPENDENT CHILD AGE 19 OR OLDER? ☐ YES ☐ NO
IF YES -YOU MUST ATTACH AN ADULT DEPENDENT CERTIFICATION FORM
18. IS CLAIMANT COVERED BY ANY OTHER BENEFIT PLAN? ☐ YES ☐ NO
19. IF YES - SHOW NAME OF COVERED EMPLOYEE PHONE NUMBER
20. SOCIAL SECURITY NO.
21. NAME OF OTHER PLAN ADDRESS
22. GROUP OR I.D. NO.
23. IS THIS CLAIM FOR AN ACCIDENT? ☐ YES ☐ NO
24. IF YES - WHERE DID IT HAPPEN?
25. DID INJURY OCCUR ON THE JOB?
26. WHEN? MO. DAY YR.
27. DESCRIBE WHAT HAPPENDED
28. IS ANOTHER PERSON RESPONSIBLE FOR THE ACCIDENT? ☐ YES ☐ NO
29. IF YES, NAME AND ADDRESS OF PERSON RESPONSIBLE FOR THE ACCIDENT OR INJURY:
30. NAME, ADDRESS, PHONE NUMBER, AND CLAIM NUMBER OF RESPONSIBLE PERSON'S INSURANCE COMPANY:

31. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby certify that the foregoing statements, including any accompanying statements, are to be the best of my knowledge and belief, true, correct and complete. I hereby authorize any provider to furnish and disclose all known facts and authorize release of medical records. I will reimburse the fund for any overpayment made to me 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 AND DATE MO. DAY YEAR

32. AUTHORIZATION TO PAY BENEFITS TO PROVIDER:

I hereby authorize payment directly to the provider, for his services described hereon, or in supplemental statements, not to exceed the reasonable and customary charges for those services. I understand that this authorization will remain in force until cancelled in writing by me.

Employee Signature X ______________________ Date ______________
SIGN ONLY IF YOU WISH TO HAVE BENEFITS PAID TO PROVIDERS MO. DAY YEAR

PART B: PROVIDER'S STATEMENT • MUST BE COMPLETED BY PROVIDER

1. PATIENT'S NAME
2. AGE
3. SEX
4. DOES PATIENT HAVE OTHER COVERAGE? IF "YES" ☐ YES ☐ NO
CO. NAME:
ADDRESS OR LOCATION:
POLICY NO.:
5. DIAGNOSIS OR NATURE OF DISEASE, INJURY, DENTAL CLAIM OR VISION DISORDER
6. DATE OF HOSPITAL CONFINEMENT
7. OCCUPATIONAL INJURY ☐ YES ☐ NO
8. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURRED MO. DAY YR.
9. DATE FIRST VISIT (CURRENT CONDITION) MO. DAY YR.
10. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
11. DATE OF TOTAL DISABILITY (UNABLE TO WORK OR PERFORM NORMAL ACTIVITIES MO. DAY YR.
12. ESTIMATED DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK MO. DAY YR.
13. DATE PATIENT RELEASED TO RETURN TO WORK MO. DAY YR.
14. HAS PATIENT HAD SAME OR SIMILAR CONDITION? IF "YES", WHEN AND DESCRIBE ☐ YES ☐ NO MO. DAY YR.
15. IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO
ESTIMATED DATE OF CONFINEMENT: MO. DAY YR.

16, DATE OF SERVICE			PLACE OF SERVICE CODE	PROCEDURE CODE "CPT. +ADA OR IDENTITY	LIST SEPARATELY - SERVICES, MATERIALS AND IFTTINGS (DENTAL - LIST TOOTH AND SURFACE)	CHARGES	CLAIMS OFFICE USE ONLY
MO.	DAY	YR.					

NOTE: PROVIDER ID NO OR SS NO. (NO. 17) MUST BE COMPLETED

17. PROVIDER TAX I.D. NO. / SS NO.
18. TELEPHONE NO.
19. DATE
TOTAL CHARGES
20. PROVIDER'S NAME AND DEGREE (PRINT)
21. SIGNATURE ✕
AMOUNT PAID
22. ADDRESS
23. CITY
24. STATE
25. ZIP
BALANCE DUE

DENTAL

HAVE SERVICES LISTED ABOVE BEEN PERFORMED? ☐ YES ☐ NO
IS TREATMENT FOR ORTHODONTIC PURPOSES? ☐ YES ☐ NO
IS TREATMENT DUE TO ACCIDENTAL INJURY? ☐ YES ☐ NO
IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO
IF "NO" DATE AND REASON FOR REPLACEMENT (NO.5 ABOVE) ☐ YES ☐ NO

LIST SEPARATELY SERVICES MATERIALS AND FITTINGS, INCLUDING CHARGES ABOVE.

VISION

PROCEDURE CODE

EX - EXAMINATION
TF - TRI-FOCAL (PAIR)
SV - SINGLE VISION (PAIR)
LT - LENTICULAR (PAIR)
BF - BI-FOCAL (PAIR)
OTH - OTHER

IS THIS THE INITIAL RX FOR LENSES OR FRAMES? ☐ YES ☐ NO
IN "NO" DATE OF PREVIOUS MO. DAY YR.
Rx

LIST SEPARATELY SERVICES, MATERIALS AND FITTNGS INCLUDING CHARGES ABOVE.

*O - PROVIDER'S OFFICE
H - PATIENT'S HOME
IH - INPATIENT HOSPITAL
**CPT
OL - OTHER LOCATION
NH - NURSING HOME
OH - OUTPATIENT HOSPITAL
+ADA - AMERICAN DENTAL ASSOC.

PART C: EMPLOYER'S STATEMENT • MUST BE COMPLETED BY EMPLOYER FOR DISABILITY CLAIM ONLY

1. DATE LAST WORKED MO. DAY YR.
2. DATE RETURNED TO WORK MO. DAY YR.
3. DID INJURY OCCOUR ON THE JOB? ☐ YES ☐ NO
4. EMPLOYEE'S GROSS WEEKLY WAGE
5. EMPLOYER (COMPANY NAME)
6. MANAGER'S SIGNATURE ✕
7. TITLE
8. DATE MO. DAY YR.