ALLIED BUILDING INSPECTORS

LOCAL 211 INTERNATIONAL UNION OF OPERATING ENGINEERS

WELFARE FUND

225 BROADWAY, 43RD FLOOR, NEW YORK, NY 10007

Phone: (212) 233-2690
Fax: (212) 962-2523

CHIROPRACTOR/PODIATRY BENEFIT CLAIM

To be completed by member:

Last Name _____ First Name _____ M.I. _____

Address _____
Street Address City State Zip Code

Home Phone _____ Social Security No. _____

Job Title _____ Agency/Dept. _____

Are you or your dependent entitled to benefits under other insurance coverage? Yes ❑ No ❑

If the answer is "YES" please check: GHI ❑ Medicare ❑ Other ❑ _____

Members Signature _____ Date _____

To be completed by Chiropractor or Podiatrist

1. Patient's Name _____ Age _____ Relation to Member _____
2. Diagnosis/Nature of sickness or injury _____

_____

3. Did this sickness or injury arise out of patients employment? Yes ❑ No ❑

If "YES", explain _____

DATE	DESCRIPTION OF SERVICES	FEE	PAID BY MEMBER*

**** Actual out of pocket paid by member (ie. GHI or Medicare Co-Pay)***

4. Have you completed any other Insurance forms for this patient? Yes ❑ No ❑

If "YES", indicate name of provided (GHI, Medicare, Etc.) _____

Name: _____ License No: _____

Address _____ Tax ID No: _____

City _____ State _____ Zip _____

Date _____ Signature _____

(Check One)

❑ CHIROPRACTOR ❑ PODIATRY

This claim form must be returned to fund office within 180 Days of first visit.

Claim will not be processed unless signed by member and Chiropractor or Podiatrist.