



Local No. 9 IBEW and Outside Contractors Health and Welfare Fund

Telephone 866-661-1021
Claims mailing address IBEW9OC
PO Box 50
Pewaukee, WI 53072-0050

Medical Care Claim Form - Retiree

INSTRUCTIONS: Complete the form below. Please see the reverse side for more detailed instructions. **Return the completed form to the address above.**

Participant's Statement of Claim for Group Health Benefits			
<p>1. Claim is being made for:</p> <p><input type="checkbox"/> Participant <input type="checkbox"/> Unmarried Child. If child is 19 or over, benefits continued as: <input type="checkbox"/> Full time student, attending _____ (Name of school)</p> <p><input type="checkbox"/> Spouse <input type="checkbox"/> Other</p>			
2. Patient's Name:		Date of Birth (mm/dd/yy):	Sex:
<p>3. Is this claim due to an accident: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of accident (mm/dd/yy): _____</p> <p>If yes, where did accident occur? _____</p> <p>Describe the accident: _____</p>			
4. Is this claim as a result of a work-related illness or injury: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>5. Are you (Participant) married? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes", is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "yes", please provide:</p> <p>_____ Name of Spouse</p> <p>_____ Employer of Spouse</p> <p>_____ Address of Employer</p>			
<p>6. Is the patient covered under any other health benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes", provide the name and address of the company or insurance carrier providing benefits:</p> <p>_____ Name of company or insurance carrier</p> <p>_____ Street _____ City _____ State Zip</p>			
<p>7.</p> <p>_____ Participant's name _____ ID Number _____ (Area Code) Telephone Number</p> <p>_____ Street _____ City _____ State Zip</p>			
<p>8. AUTHORIZATION TO RELEASE INFORMATION:</p> <p>I hereby certify that the foregoing statements are true and correct to the best of my knowledge. I also authorize any hospital, physician, or other persons who have attended me or examined me or any of my dependents, to disclose to Carday and Associates, Inc. and/or my Plan any and all information with respect to any illness or injury, medical history, consultation, diagnosis or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.</p>		<p>_____ Patient's signature _____ Date</p> <p>_____ Participant's signature _____ Date</p>	
<p>9. ASSIGNMENT OF BENEFITS:</p> <p>I hereby authorize payment directly to the provider of medical services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.</p>		<p>_____ Participant's signature _____ Date</p>	

Instructions for Filing a Claim

Complete the Participant's Statement: Please be sure to answer every question.

All bills must show patient's name, date(s) of treatment, nature of treatment (diagnosis) and fee for each service.

If claim is for registered nurses, x-ray, laboratory or medical equipment, attach bills to the form after completing "Participant's Statement of Claim" section. All bills must show: patient's name; nature and date(s) of service; amount of charge; and prescribing physician. Additional data will be requested if needed.

This list follows the numerical order on the claim form:

1. Check the appropriate box for whom the claim is being made.
2. Provide the patient's name, date of birth, and sex.
3. Check the appropriate box (Yes or No) if the claim is due to an accident. State where the accident occurred and the date of the accident. Please provide a brief description of the accident.
4. Check the appropriate box (Yes or No) if the claim is work-related.
5. Check the appropriate box(es) if the Participant is married and if the spouse is employed. Provide the employer's name and address. If the claim is for a dependent child, check the appropriate box if the child is employed. Provide the employer's name and address.
6. If the patient is eligible for benefits under another plan, please check the appropriate box and provide the name and address of the insurance carrier or company providing the other benefits for the patient.
7. Provide the Participant's name and address.
8. Sign and date the claim form.
9. Sign and date the Assignment of Benefits, if applicable.
10. Provide the Participant's name and address.

Mail the claim form and the itemized bill to:

IBEW9OC
PO Box 50
Pewaukee, WI 53072-0050

IMPORTANT ITEMS TO NOTE:

1. All charges must be submitted within the time frame specified in the summary plan description. Failure to do so will result in the denial of the charges.
2. From time to time, additional information may be requested in order to process a claim. Any additional information, i.e., other insurance payments, completed claim forms, subrogation forms, accident details, police reports, etc., must be submitted when requested. Failure to do so may result in the denial of your claim.
3. **ALWAYS retain a copy for your records.**