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

Telephone 866-661-1021
Claims mailing address BCBSIL
PO Box 850107
Chicago, IL 60680-4112

Medical Care Claim Form – Actives

INSTRUCTIONS: Complete the form below. Please see the reverse side for more detailed instructions.

Participant's Statement of Claim for Group Health Benefits

1. Claim is being made for:

[ ] Participant [ ] Unmarried Child. If child is 19 or over, benefits continued as: [ ] Full time student, attending _____ (Name of school)

[ ] Spouse [ ] Other

2. Patient's Name: Date of Birth (mm/dd/yy): Sex:

3. Is this claim due to an accident: [ ] Yes [ ] No If yes, date of accident (mm/dd/yy): _____

If yes, where did accident occur? _____

Describe the accident:

4. Is this claim as a result of a work-related illness or injury: : [ ] Yes [ ] No

5. Are you (Participant) married? [ ] Yes [ ] No

If "Yes", is your spouse employed? [ ] Yes [ ] No

If "yes", please provide:

_____
Name of Spouse

_____
Employer of Spouse

_____
Address of Employer

If claim is for a Dependent Child, is the Dependent Child employed?

[ ] Yes [ ] No

If "Yes", please provide

_____
Name of Dependent

_____
Employer of Dependent

_____
Address of Employer

6. Is the patient covered under any other health benefits: [ ] Yes [ ] No

If "Yes", provide the name and address of the company or insurance carrier providing benefits:

_____
Name of company or insurance carrier

_____ _____ _____ _____
Street City State Zip

7.

_____ _____ _____
Participant's name BCBS ID No. (Area Code) Telephone Number

_____ _____ _____ _____
Street City State Zip

8. AUTHORIZATION TO RELEASE INFORMATION:

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.

_____ _____
Patient's signature Date

_____ _____
Participant's signature Date

9. ASSIGNMENT OF BENEFITS:

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.

_____ _____
Participant's signature Date

Local Union No. 9, IBEW and Outside Contractors Health and Welfare Fund **BCBS Group No. P015016**

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.

KEEP A COPY FOR YOUR RECORDS

Mail medical claim forms and itemized bill to:

Blue Cross Blue Shield of Illinois
PO Box 805107
Chicago, IL 60680-4112

IMPORTANT ITEMS TO NOTE:

1. Claims 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.**