PRINT

INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
Telephone (812) 238-2551 Toll Free (800) 962-3158
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SUBSTANCE ABUSE CLAIM FORM

Member Name: _____ Member ID#: _____

Patient Name: _____

Name of Facility: _____

Name of Medical Doctor ordering or supervising treatment: _____

In-Patient: ☐ If in-patient, does your facility have a physician and registered nurse on staff 24 hours per day, 7 days per week? ☐ YES ☐ NO

Out-Patient Therapy: ☐

Out-Patient Medical Treatment only (no therapy): ☐
☐ Methadone ☐ Suboxone ☐ Other: _____

Is treatment incurred from or occurring during an attempt to commit or the commission of a misdemeanor or felony or the willful participation in a public disturbance or riot and as a direct result of driving while legally impaired, whether or not court-ordered? ☐ YES ☐ NO

Beginning date of treatment: _____

Plan of treatment: _____

_____

_____

Is the provider of service In-Network with the Fund's Preferred Provider Organization: Anthem?
☐ YES ☐ NO

_____ _____
Signature of Provider or Authorized Representative Date