MEDICAL CLAIM FORM

Return to the following address:
IBEW LOCAL 102 WELFARE FUND
425 Eagle Rock Avenue, Suite 105
Roseland NJ 07068
Tel: 888-IBEW102 (423-9102)

Member's Name (print in full)	Policy or Plan No. **CSO-77**	Social Security Number ☐☐☐-☐☐-☐☐☐☐
Home Address City State Zip	Date of Birth	Daytime Phone Number
	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed	Work Status ☐ Active ☐ Disabled ☐ Retired ☐ Other (specify)

PATIENT INFORMATION

Name Soc. Sec. No.	Date of Birth
Relationship To Member ☐ Self ☐ Spouse ☐ Child* ☐ Other (specify)	Sex ☐ Male ☐ Female

* If Child: Married? ☐ Yes ☐ No Full-time Student? ☐ Yes ☐ No

Medical Coverage Effective Date
☐ Hospital (Part A) Only ☐ Both (A & B)
☐ Medical (Part B) Only ☐ None

SPOUSE INFORMATION

Name	Date of Birth
Social Security Number ☐☐☐-☐☐-☐☐☐☐	Employment Status ☐ Active ☐ Retired ☐ Not Employed
Employer Name and Address	

Describe sickness or injury, if injury, where and how did it occur?

Date sickness began or injury occurred	Did injury occur at work? ☐ Yes ☐ No Was sickness caused by work? ☐ Yes ☐ No	Was injury caused by an automobile accident? ☐ Yes ☐ No If yes, specify city & state above

IF YOU OR ANY MEMBER OF YOUR FAMILY IS COVERED UNDER ANOTHER GROUP HEALTH PLAN, COMPLETE THE FOLLOWING SECTION

Covered Family Member ☐ Self ☐ Patient ☐ Spouse ☐ Other (specify Name and Relationship)			Name and Address of Insurance Company
Policy or Plan No.	Insurance I.D. Number	Type of Coverage ☐ Individual ☐ Family	

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

AUTHORIZATION FOR RELEASE OF INFORMATION: I/We authorize the release to ULLICO and its agents of any evidence or information about me or my dependent(s) that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original. (Patient's signature is required if patient is a legal adult)

Member's Signature Date Patient's Signature Date

INSTRUCTIONS FOR MAKING CLAIM FOR BENEFITS 1. Answer all required questions on this side of form, and sign it.
2. If you want us to pay the Hospital or Doctor directly, sign the "Assignment of Benefits" section on the reverse.
3. Have the doctor complete his section or attach an itemized bill indicating the patient's name, diagnosis, the type, place and date of each service, and the amount charged.

THIS SECTION TO BE COMPLETED BY POLICYHOLDER

Member Effective Date	Member Termination Date
I certify that the patient named in this claim was eligible for medical benefits during the period specified above Policyholder's Representative Date	

EMPLOYER / DISABILITY INFORMATION

1. From what date was he continuously employed?
2. On what date did he last work prior to his disability? Weekly Wage $
3. Is this disability the result of injury or occupational disease arising out of or in the course of employment?
4. If the cause of disability was occupational, has it been reported to the state board or commission or to any insurance company as a workmen's compensation claim?

   If not, please state the reasons:
5. If the employee has returned to work, please indicate exact date:

Name of Employer

Employer's Tax I.D. Number By

Address of Employer

ASSIGNMENT OF BENEFITS	I authorize payment of benefits to the undersigned physician or supplier for the services described below. Member's Signature Date

PHYSICIAN OR SUPPLIER INFORMATION: These Sections To Be Completed by Physician Unless Claim Is Submitted With An Itemized Bill

Patient's Name (print in full)	**IF PATIENT IS / WAS UNABLE TO WORK**
Date of illness (first symptoms) injury (accident) or pregnancy (LMP) / Date first consulted for this condition	Date patient able to return to work
Has patient ever had similar symptoms? ☐ Yes ☐ No If yes, when?	Dates of Total Disability from through
Referring Physician	
Facility where services were rendered (If other than home or office)	Dates of Partial Disability from through

ICDA CODES AND DESCRIPTIONS OF DIAGNOSES: Relate To Services Below With Numbers At Left

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HOSPITALIZATION: USE UB-92 CODES

Admission Date	Type Code	Source Code
Discharge Date	Discharge Status Code	

↓	PLACE OF SERVICE*	PROCEDURE (CPT/RVS)	DESCRIPTION OF PROCEDURE, SERVICE, OR SUPPLY FURNISHED *Explain unusual services or circumstances*	DATES OF SERVICE From To	DAYS/ UNITS	CHARGES

Physician's or Supplier's Name, Address, and Telephone Number *(print)*	Patient's Account Number	Total Charges
	Physician's Tax I.D. Number	Amount Paid
		Balance Due

ULLICO WILL NOT ACCEPT AN ASSIGNMENT OF BENEFITS WITHOUT THE PHYSICIAN'S OR SUPPLIER'S TAX IDENTIFICATION NUMBER

Physician's Signature Date