

Northwest Ironworkers Health and Security Trust

EMPLOYEE STATEMENT					
<input type="checkbox"/> Check here if your address is new. <div style="float: right; text-align: right;">PART 1 - EMPLOYEE INFORMATION</div>					
EMPLOYEE'S NAME – First Initial Last			<input type="checkbox"/> M <input type="checkbox"/> F		EMPLOYEE IDENTIFICATION NUMBER
HOME ADDRESS STREET CITY STATE ZIP			EMPLOYEE BIRTHDATE Mo. Day Year		PHONE
EMPLOYED BY			LOCAL NO.		EMAIL
PATIENT'S NAME – First Initial Last			<input type="checkbox"/> M <input type="checkbox"/> F		PATIENT SOCIAL SEC. NO.
PATIENT BIRTHDATE Mo. Day Year			RELATION TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		PATIENT ADDRESS (IF DIFFERENT THAN EMPLOYEES ADDRESS)
STREET CITY STATE ZIP			PHONE		EMAIL
EMPLOYEE MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGAL SEP. <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> ADOPTED CHILD <input type="checkbox"/> FOSTER CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> GUARDIANSHIP <input type="checkbox"/> OTHER (EXPLAIN) _____ IF DEPENDENT CHILD THROUGH LEGAL CUSTODY OR LEGAL GUARDIANSHIP IS AGE 19 OR OLDER, IS CHILD ENROLLED AS A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF SCHOOL _____		IF DEPENDENT CHILD IS AGE 26 OR OLDER, DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME OF SPOUSE (if not patient listed above)			SPOUSE BIRTHDATE		SPOUSE SOCIAL SECURITY NO.
IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO			NAME AND ADDRESS OF SPOUSE'S EMPLOYER		
PART 2 – INSURANCE INFORMATION					
ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN or MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER _____ NAME OF INSURED _____ INSUREDS IDENTIFICATION OR SOCIAL SECURITY NO. _____ OTHER INSURANCE COVERS: <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN OTHER INSURANCE INCLUDES: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION OTHER GROUP PLAN POLICY OR I.D.# _____ MEDICARE EFFECTIVE DATE PART A _____ PART B _____ PART D _____					
PART 3 – ACCIDENT/INJURY INFORMATION					
WAS CARE REQUIRED BECAUSE OF AN INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DID ACCIDENT OCCUR WHILE AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INJURED _____ DESCRIBE HOW INJURY OCCURRED: _____ HAS CLAIM BEEN FILED WITH LABOR AND INDUSTRIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", GIVE CLAIM NUMBER _____ FOR TIME LOSS: LAST DAY WORKED _____ DATE RETURNED TO WORK _____					
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his or her services but not to exceed the reasonable and customary charge for those services. Do not sign if bills have been paid.			I hereby certify that the foregoing statements, including any accompanying statements, are true and correct and complete to the best of my knowledge, and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning MY physical condition that are within their knowledge. A photocopy of this authorization is as valid as the original. Patient Signature (if not minor child) _____ Employee Signature _____ Date _____ Employee Signature _____ Date _____		

PROCEDURE FOR FILING A CLAIM

1. Complete all applicable sections of the "Employee Statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim.
2. Attach an itemized bill for all charges relating to this claim.
3. If claim is for disability, a doctor MUST complete the "Attending Physician's Statement" below.
4. Complete a separate form for each patient.
5. **Mail completed form and itemized bills to:**

Northwest Ironworkers Health and Security Trust
P.O. Box 34464
Seattle, WA 98124-1464
Phone: (206) 441-7226 or 1-866-986-1515
Email: claimstatus@wpas-inc.com
Fax: (206) 441-9110

To ensure prompt payment submit only itemized bills. An itemized bill is the actual bill from the provider showing: a) date of service; b) diagnosis; c) procedure done and d) cost of each procedure. A "balance due" or non-itemized bill is NOT acceptable.

Prescription drugs must have actual pharmacy receipt showing a) name of pharmacy; b) name of patient; c) date prescription is filled and d) name and cost of drug. A cash register receipt is NOT acceptable.

If you have other Group Insurance or Medicare as your primary coverage you need to submit the itemized bill AND a copy of the matching insurance or Medicare payment explanation.

ATTENDING PHYSICIAN'S STATEMENT – For Disability Claim

PATIENT'S NAME		AGE	
DIAGNOSIS AND CONCURRENT CONDITIONS			
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", APPROXIMATE DATE PREGNANCY COMMENCED. DATE: _____			
COMPLETE REPORT OF SERVICES OR ATTACH AN ITEMIZED BILL IF A PREVIOUS FORM HAS BEEN SUBMITTED, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT.			
DATE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	C.P.T. PROCEDURE CODEs	CHARGES
		TOTAL CHARGES	\$
		AMOUNT PAID	\$
		BALANCE DUE	\$
DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE
STREET ADDRESS		CITY – STATE – ZIP CODE	
		INDIVIDUAL PRACTITIONERS TIN OR SS# NPI#	

1520 – 1/2021

BENEFIT, CLAIMS PAYMENT AND ELIGIBILITY INFORMATION
MAY BE OBTAINED FROM:
WELFARE & PENSION ADMINISTRATION SERVICE, INC.
PHONE: (206) 441-7226 OR 1-866-986-1515
www.ironworkerstrust.com