PLAN 15M

MEDICAL and PRESCRIPTION DRUG CLAIM FORM FOR:
ACTIVES, COBRA and NON-MEDICARE RETIREES

Northwest Ironworkers Health and Security Trust

EMPLOYEE STATEMENT

☐ **Check here if your address is new.** **PART 1 - EMPLOYEE INFORMATION**

EMPLOYEE'S NAME – First Initial Last	☐ M ☐ F	EMPLOYEE IDENTIFICATION NUMBER	EMPLOYEE BIRTHDATE Mo. Day Year
HOME ADDRESS STREET CITY STATE ZIP			PHONE
			EMAIL
EMPLOYED BY			LOCAL NO.

PATIENT'S NAME – First Initial Last	☐ M ☐ F	PATIENT SOCIAL SEC. NO.	PATIENT BIRTHDATE Mo. Day Year	RELATION TO EMPLOYEE ☐ Self ☐ Spouse ☐ Child

PATIENT ADDRESS (IF DIFFERENT THAN EMPLOYEES ADDRESS)	STREET CITY STATE ZIP	PHONE EMAIL

EMPLOYEE MARITAL STATUS	IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU	IF DEPENDENT CHILD IS AGE 26 OR OLDER, DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP?
☐ MARRIED ☐ LEGAL SEP. ☐ SINGLE ☐ WIDOWED ☐ DIVORCED	☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ FOSTER CHILD ☐ STEP CHILD ☐ GUARDIANSHIP ☐ OTHER (EXPLAIN) _____ IF DEPENDENT CHILD THROUGH LEGAL CUSTODY OR LEGAL GUARDIANSHIP IS AGE 19 OR OLDER, IS CHILD ENROLLED AS A FULL-TIME STUDENT? ☐ YES ☐ NO NAME OF SCHOOL _____	☐ YES ☐ NO

NAME OF SPOUSE (if not patient listed above)	SPOUSE BIRTHDATE	SPOUSE SOCIAL SECURITY NO.
IS SPOUSE EMPLOYED? ☐ YES ☐ 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? ☐ YES ☐ NO

IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER_____

NAME OF INSURED _____ INSUREDS IDENTIFICATION OR SOCIAL SECURITY NO._____

OTHER INSURANCE COVERS: ☐ PATIENT ☐ SPOUSE ☐ CHILDREN

OTHER INSURANCE INCLUDES: ☐ MEDICAL ☐ DENTAL ☐ VISION NAME OF PERSON COVERED BY MEDICARE _____

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? ☐ YES ☐ NO DID ACCIDENT OCCUR WHILE AT WORK? ☐ YES ☐ NO

DATE INJURED_____ DESCRIPE HOW INJURY OCCURRED:_____

HAS CLAIM BEEN FILED WITH LABOR AND INDUSTRIES? ☐ YES ☐ 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.

Employee Signature_____ Date_____

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 _____

SEE OTHER SIDE FOR INSTRUCTIONS

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? ☐ YES ☐ NO PREGNANCY? ☐ YES ☐ NO IF "YES", APPROXIMATE DATE PREGNANCY COMMENDED. 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	TELEPHONE
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