SELF-FUNDED MEDICAL CLAIM STATEMENT
SUBMIT WITHIN 90 DAYS

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN ONLY.

ITEMIZED BILLS AND COMPLETED FORM TO:
U.A. LOCAL NO. 467 HEALTH AND WELFARE TRUST FUND
P.O. BOX 5057 SAN JOSE, CA 95150 PHONE (408) 288-4400

PART I–MEMBER MUST COMPLETE (PLEASE TYPE OR PRINT)

Member's Social Security No.	Last Name	First Name	Member's Phone No.

Address	Street	City	State	Zip

Patient's Name and Social Security No.	Birthdate Mo / Day / Yr	If Dependent Relationship	Are these charges due to a work incurred illness or injury? ☐ Yes ☐ No	Employer

If charges submitted are due to an accidental injury, state how, when and where

IS THIS PATIENT COVERED BY ANOTHER INSURANCE PLAN?
YES ☐ NO ☐ IF YES, ANSWER THE FOLLOWING:

PLAN NAME _____ AND ADDRESS _____

NAME OF INSURED PERSON _____
S.S.# _____
EMPLOYER _____
GROUP # _____

MEMBER'S STATEMENT:
I hereby certify that the foregoing statements including any accompanying statements are true, correct and complete to the best of my knowledge and hereby authorize the attending physician or practioner and the hospital in which the confinement took place, if any, to furnish and disclose all records and information concerning the patient's physical condition that are within their control or knowledge.
I further authorize, on behalf of myself and my dependent, if any, U.A. Local No. 467 Health and Welfare Trust Fund to use or disclose any information contained in its file in whatever manner it deems necessary for the purpose of determining the reasonableness of any of the expenses submitted herewith or the propriety of this claim.

THIRD PARTY LIABILITY:
I AGREE to reimburse the Fund for any benefits paid by the Fund on this claim to the extent of any recovery from any third party responsible for the injury or sickness upon which it is based.

Date Signed _____ Member's Signature _____

MEMBER'S AUTHORIZATION:
I hereby authorize U.A. Local No. 467 Health and Welfare Trust Fund to pay to the below named physician any payments otherwise due and payable to be for medical services rendered to me or one of my eligible dependents by the below named physician.

Date Signed _____ Member's Signature _____

PART II–PHYSICIAN MUST COMPLETE (PLEASE TYPE OR PRINT)

HAVE YOU COMPLETED ALL ITEMS?

Name of Patient	Does the patient have other health plan coverage?	Name of Health Plan

Physician's Diagnosis (describe complications if any)

Check one: Sickness ☐ Accident ☐	Is disability due to work incurred condition? Yes No	Is disability due to pregnancy? Yes No	Is disability due to alcoholism or narcotic addiction? Yes No

Name of Hospital (if hospitalized)	Admission Date	Discharge Date

IF MEMBER IS FILING FOR DISABILITY CREDIT, THESE QUESTIONS MUST BE ANSWERED BY THE ATTENDING PHYSICIAN

PHYSICIAN OR SUPPLIER INFORMATION

Date of Illness (first symptom) or Injury (accident) or Pregnancy (LMP)	Date first consulted you for this condition	Has patient ever had same or similar symptoms? Yes ☐ No ☐

Date patient able to return to work	Dates of total disability From	Through	Dates of partial disability From	Through

Name of Referring Physician	For services related to hospitalization, give hospitalization dates Admitted	Discharged

Name and Address of facility where services rendered *(if other than home or office)*	Was laboratory work performed outside your office? Yes ☐ No ☐ Charges

Diagnosis or nature of illness or injury
1
2

PHYSICIAN'S STATEMENT
I hereby authorize the U.A. Local No. 467 Health and Welfare Trust Fund or its representatives to examine all medical records pertaining to the disability of the above named patient.

Date Signed _____ Physician's Signature _____

Assignment not Acceptable unless physician I.R.S. or Soc. Sec. No. furnished.	Physician's Soc. Sec. No. or IRS Taxpayer's ID No.	Physician's Name (please print)	Telephone

Street _____ City _____ State _____ Zip _____

REV. (7/99)

CAUTION: ONLY THE PLAN OFFICE CAN VERIFY ELIGIBILITY. A STATEMENT OF ELIGIBILITY FURNISHED BY A LOCAL UNION OR OTHER SOURCE WILL NOT BE HONORED IF IN ERROR.