Medical / Dental / Vision / Prescription / Weekly Disability Claim Form

NW PLUMBERS & PIPEFITTERS HEALTH FUND

A Self-Funded Health Plan

P. O. Box 34203, Seattle, WA 98124-1203

Instructions: Complete this form, attach all item administrator at the address above, &		For Assistance Nationwide Call: Welfare & Pension Administration Service Claims Office 1-800-331-6158			
PART I - TYPE OF CLAIM:	Check type(s):	☐ Medical☐ Prescription	□ Dental□ Weekly	□ Vision Disability	
PART II - EMPLOYEE DATA:					
Employee Name: (First Name)	(Last Name)		_ Member Cert #	# :	
Mailing Address: (Street)		(City)		(State) (Zip)	
PART III - PATIENT DATA:	Claim is for:	□ Employee	□ Spouse	□ Dependent Child	
Patient Name: (First Name)	(Last Name)		Birth	Date:/	
If child is age 19 or older, is child a tage	orm must be on file al disability, physical		□ Chile	is for dependent child, indicate relationship: d □ Step Child □ Legal Guardianship r	
PART IV - OTHER INSURANCE	E INFORMATION:				
Does patient have other health insura Insurance company/plan administrate 1. 2. Is spouse employed? □ Yes □ N	or's name, address, tele	ephone #, policy/pla	n #, and types of	coverage: □ Medical □ Dental □ Vision □ Medical □ Dental □ Vision	
PART V - CLAIM INFORMAT	ON (complete only a	applicable informat	tion):		
Are expenses related to an accident?	□ Yes □ No	If yes, inc	licate date of acci	ident/ and type of accident:	
□ Automobile					
☐ Employment-Related: Name, addı	ess & telephone of em	ployer:			
□ Home/Recreational □ O	ther				
Note: If claim is related to an accia PART VI - AUTHORIZATION	•	-	onnaire". Respo	nd promptly to expedite claim processing.	
Administration Service, Inc. (WPAS) history, symptoms, treatment, examin	and the planholder, or ation results or diagno at to defraud any insu	r their representative osis. This authorizati urance company or o	s, any information ion shall be consid	provider to release to Welfare & Pension regarding my and/or my dependent's health dered valid for the duration of the claim. <i>Any</i> a statement of claim containing any false,	
I AUTHORIZE BENEFIT PAYMEN CLAIM FORM. □ Yes		PROVIDER FOR T	HE SERVICES A	ND/OR SUPPLIES DESCRIBED ON THIS	
				1 1	

Eligible Participant's Signature

Date

311D 2/03

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME		AGE			
DIAGNOSIS AND CONCURRENT CONDITIONS					
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES NO					
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 DESCRIPTION OF SERVICES SERVICES RENDERED		PROCEDURES CODE	CHARGES		
		TOTAL CHARGES	\$		
		AMOUNT PAID	\$		
		BALANCE DUE	\$		
THIS AREA MUST BE COMPLETED BY THE ATTENDING PHYSICIAN IF APPLYING FOR WEEKLY DISABILITY BENEFITS					
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST SEEN FOR THIS CONDITION				
PATIENT EVER HAD SAME OR SIMILAR CONDITION?		PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?			
YES □ NO □ IF "YES", WHEN AND DESCRIBE:		YES NO			
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) GIVE DATES		LAST DAY WORKED			
FROM THRU IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	DATE EMPLOYEE RETURNED TO WORK				
DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES DOWN DOWN IF "YES", PLEASE IDENTIFY					
DATE PHYSICIAN'S NAME (PRINT) SIGNATURE		REE TELEPHONE			
STREET ADDRESS CITY – STATE – ZIP CODE		INDIVIDUAL PRACTITIONERS	TIN OR SS#		

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 or prescription receipts for all charges related to this claim. **If claim is for disability, a doctor MUST complete** the "Attending Physician's Statement" shown above.
- 3. Complete a separate form for each patient.

4. Mail completed form and itemized bills to: NW Plumbers and Pipefitters Health Fund

P.O. Box 34203

Seattle, WA 98124-1203

5. For electronic claims submission: Group F31 WebMD ID 91136

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.

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 Medicare or other insurance payment explanation.