

EMPLOYEE: IT IS YOUR RESPONSIBILITY TO COMPLETE AND SIGN THE EMPLOYEE'S STATEMENT BELOW:

CLAIM FOR BENEFITS

HOW TO FILE YOUR CLAIM

1. You must FULLY COMPLETE the EMPLOYEE'S STATEMENT and SIGN IT.
2. Attach the bills for the medical expense benefits you are claiming. These bills must be itemized and show the patients name, condition being treated (diagnosis), type of treatment given, date the expense incurred and the charges made.
3. A Physician's Statement is provided on the back of this form for your convenience.
4. RETURN FULLY COMPLETED FORM with attached medical claims to address below.

EMPLOYEE'S STATEMENT						
Fully Complete For All Claims	Employee's Name (Please Print)		Group Number 41593	Birthday (MO. DA. YR.)		Social Security Number
	Address: Street and No.		City	State	Zip Code	
	I am: <input type="checkbox"/> Active <input type="checkbox"/> Retired		This claim is on:		<input type="checkbox"/> Myself <input type="checkbox"/> Wife/Husband <input type="checkbox"/> Dependent Child	
	Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give name of spouse and name and address of spouse's employer.	
	Name of Spouse _____ Name of Spouse _____		Spouse's Birthday _____		Social Sec. No. _____	
Complete For All Claims	Name of Spouse's Employer _____		Address _____			
	What was the sickness or injury?			On what date did it begin?		Date of first expense for this condition
	Are any of the expenses being claimed covered by:					
	(a) Other group health care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		(c) A group Blue Cross Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Give name of Employer _____ Other insurance company and policy number _____		Give group number _____ Give certificate number _____			
(b) Government insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		(d) School insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What type? _____						
Is COBRA applicable? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of COBRA _____						
If these expenses are covered by other insurance and the other carrier is primary (that is, pays first), don't file this claim until you have received the payment from the other insurance. Submit the explanation of benefits from the other carrier with this claim.						
Complete For All Injuries Employee or Dependent	Date the injury?	Where did the injury occur?		How did the injury occur?		
	Is injury due to automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has or will claim be filed under any Worker's Compensation Act or similar law? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Complete Only For Dependent Claims	Name of dependent		Birthday (MO. DA. YR.)	Relationship of dependent		
					<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	
Date you covered this Dependent	If child 19 or over is (s)he dependent upon your maintenance and support? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is (s)he a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If student give name and location of school.						
Complete Only For Disability Claims	From and to what dates were you continuously totally disabled from performing any work?					
	From _____ 20 ____ to _____ 20 ____					
Date you were first able to do any work? _____						
Sign Here	I hereby authorize the release to and use by the ILA Employers Welfare Fund of any medical or other information needed in processing this claim and certify that the above information is correct.					
	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. I hereby certify to the above statements.					
Date _____ 20 ____ Employee sign here X _____						
ADMINISTRATIVE STATEMENT						
The above Employee's Name, Address, Group Number and Social Security Number are correct <input type="checkbox"/>			Was coverage in effect when expense incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please file claim with:						
ILA EMPLOYERS WELFARE FUND 510 W. BRYAN STREET P.O. BOX 1280 SAVANNAH, GEORGIA 31498-1280			SIGNED _____ DATE _____			
Remarks:						

MEDICAL CARE CLAIM FORM
TYPE OR PRINT

PATIENT & EMPLOYEE (SUBSCRIBER) INFORMATION		
1. PATIENTS' NAME (First name, middle initial, last name)	2. PATIENTS BIRTHDATE (MO. DA. YR.)	3. EMPLOYEE'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, Zip code)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. EMPLOYEE'S I.D. No. or MEDICARE No. (include any letters)
	7. PATIENT'S RELATION TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. EMPLOYEE'S GROUP NO. (Or Group Name)
9. OTHER HEALTH CARE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number.	10. WAS CONDITION RELATED TO: A. ON THE JOB INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO B. ACCIDENTAL INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO C. AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	11. EMPLOYEE'S ADDRESS (Street, city, state, Zip code)
	12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <i>I Authorize the Release of any Medical Information Necessary to Process this Claim.</i>	
SIGNED _____ DATE _____		SIGNED (Employee or Authorized Person) _____

PHYSICIAN OR SUPPLIER INFORMATION			
14. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	19. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
20. NAME OF REFERRING PHYSICIAN		21. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES _____	
22. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)			

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1,2,3, ETC. OR DX CODE.

A

- 1.
- 2.
- 3.
- 4.

24. A. DATES OF SERVICE		B.* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.** T.O.S.	H. LEAVE BLANK
FROM	TO								

25. SIGNATURE OF PHYSICIAN OR SUPPLIER	26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/>	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNED _____ DATE _____	30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
	32. YOUR PATIENT'S ACCOUNT NO.			

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|---|---|
| <p>* PLACE OF SERVICE CODES</p> <ul style="list-style-type: none"> 11 - Office 12 - Home 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center 25 - Birthing Center 26 - Military Treatment Facility 31 - 32 - Nursing Facility 33 - Custodial Care Facility 34 - Hospice 41 - 42 - Ambulance (land, air or water) 51 - 52 - 56 - Psychiatric Facility 53 - Community Mental Health Center 54 - Intermediate Care Facility/Mentally Retarded 55 - Residential Substance Abuse Treatment 61 - Comprehensive Inpatient Rehabilitation 62 - Comprehensive Outpatient Rehabilitation 65 - End Stage Renal Disease Treatment 71 - 72 - Health Clinic 81 - Independent Laboratory 99 - Other Unlisted Facility | <p>** TYPE OF SERVICE CODES</p> <ul style="list-style-type: none"> 01 - Medical Care 02 - Surgery 03 - Consultation 04 - X Ray Interpretation 05 - Diagnostic Laboratory 06 - Radiation Therapy 07 - Anesthesia 08 - Assistance at Surgery 09 - Other Medical Service 00 - Blood or Packed Red Cells A - Used DME M - Alternate Payment for Maintenance Dialysis Y - Second Opinion on Elective Surgery Z - Third Opinion on Elective Surgery 31 - X-Ray and Interpretation |
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