

Social Security or AID No. _____

**ACCIDENT & SICKNESS
DISABILITY**

**GSA-ILA EMPLOYERS WELFARE FUND
ACCIDENT AND SICKNESS DISABILITY
MEDICAL CARE CLAIM FORM**

**PHYSICIAN OR
SUPPLIER**

PHYSICIAN OR SUPPLIER: IT IS YOUR RESPONSIBILITY TO ENSURE THIS FORM IS COMPLETE AND TO SIGN BELOW.

SECTION A. PATIENT AND EMPLOYEE (SUBSCRIBER) INFORMATION			
1. Patient's Full Name (Please Print)	5. Patient's Relation to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. Employee's Full Name (Please Print)	
2. Patient's Address (Street, City, State, Zip)	6. Was Condition Related to: A. On the job injury: <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____	8. Employee's Address (Street, City, State, Zip)	
3. Patient's Birthdate (Mo/Da/Yr)	B. Accidental Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____	9. Employee's Birthdate (Mo/Da/Yr)	
4. Patient's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	C. Auto Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____	10. Employee's Social Security or AID Number	
12. Other Health Care Coverage – Enter name of policyholder, Plan name, address, and policy or medical assistance number:		11. Employee's Daytime Telephone Number	
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. <i>I Authorize the Release of any Medical Information Necessary to Process this Claim.</i> SIGNED _____ DATE _____		14. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW. THIS AUTHORIZATION IS INVALID UNLESS TAXPAYER IDENTIFICATION NUMBER (TIN) OF PHYSICIAN OR SUPPLIER IS PROVIDED BELOW. SIGNED _____ DATE _____	

SECTION B. EXAMINING PHYSICIAN OR SUPPLIER INFORMATION – TO BE COMPLETED BY PHYSICIAN OR SUPPLIER		
15. Physician or Supplier's Full Name (Please Print):	Physician or Supplier's Address: (Street, City, State, Zip)	
16. Telephone Number:	17. Taxpayer Identification Number (TIN) or the Physician or Supplier's Social Security Number:	18. Patient's Account No.:

SECTION C. EVALUATION AND DIAGNOSIS. <i>Please attach any related medical records and test results which enabled you to make your diagnosis.</i>						
19. Date of Illness (First Symptom) or Injury (Accident) (Mo/Da/Yr): _____			23. Dates during which the Patient was unable to work at his/her regular job because of sickness, disease, or bodily injury which required treatment (Mo/Da/Yr): From: _____ To: _____			
20. Date Patient First Consulted you for this Condition (Mo/Da/Yr): _____			From: _____ To: _____			
21. Date Patient able to Return to Work (Mo/Da/Yr): _____			From: _____ To: _____			
22. Is Patient unable to work at his/her regular job because of sickness, disease, or bodily injury which required the treatment referenced herein? <input type="checkbox"/> Yes <input type="checkbox"/> No			*NOTE: The dates of disability cannot be prospective, but may only be through the date of this <i>Medical Care Claim Form</i> .			
24. Are the time periods of sickness, disease, or bodily injury described above in Number 23, due to the same or related causes? <input type="checkbox"/> Yes <input type="checkbox"/> No			26. Please briefly describe the diagnosis or nature of sickness, disease, or bodily injury:			
25. Dates of Service (Mo/Da/Yr)		Procedure Codes	Place of Service Codes	Diagnosis Codes	27. Fully Describe the Procedures, Medical Services, or Supplies Furnished for Each Date Given:	
From	To					

COUNTY OF CHATHAM)
STATE OF GEORGIA) **ACKNOWLEDGMENT**

The undersigned hereby acknowledges that he/she understands that it is a crime to knowingly make false statements and representations of fact, or knowingly conceal, cover-up, or fail to disclose any required fact, in any document required by or is necessary to verify, explain, clarify or check for accuracy and completeness of any report required by the Employee Retirement Income Security Act of 1974 ("ERISA") and that any false statement or representation made in reporting may subject him/her to prosecution under 18 U.S.C. §1027, the penalty for which is a fine of \$10,000.00 or imprisonment of five (5) years or both. By signing below, the undersigned further hereby acknowledges and agrees to periodic audits in reference to said claims by GSA-ILA Employers Welfare Fund auditors. I further hereby certify that the procedures as indicated above have been completed and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.

(Name of Physician) _____ Date: _____ Physician or Supplier signs here **X** _____

Please file claim and related documents with: Mailing Address: ILA EMPLOYERS WELFARE FUND POST OFFICE BOX 1280 SAVANNAH, GEORGIA 31402-1280	PLACE OF SERVICES CODES		
	11 – Office	33 – Custodial Care Facility	65 – End-Stage Renal Disease Treatment Facility
	12 – Home	34 – Hospice	71 – 72 – Health Clinic
	21 – Inpatient Hospital	41 – 42 – Ambulance (land, air or water)	81 – Independent Laboratory
	22 – Outpatient Hospital	51 – 52 – 56 – Psychiatric Facility	99 – Other Place of Service