



Return completed form to:  
**I.A.T.S.E. Local #16**  
**HEALTH & WELFARE TRUST FUND**  
**4160 Dublin Boulevard, Suite 400,**  
**Dublin, CA 94568-7756.**

**Instructions**  
 Part 1. Insured completes (please print).  
 Part 2. Insured completes only if payment is to be made directly to Physician.  
 Part 3. Physician completes form with all bills to the address shown at left.

**MEDICAL CLAIM FORM**

PART 1 INSURED MEMBER COMPLETES	EMPLOYEE'S NAME (First) (Last)		EMPLOYER (Name of company you work for)							
	ADDRESS		DATE EMPLOYED		OCCUPATION					
	CITY, STATE		ZIP CODE	SOCIAL SECURITY NUMBER	LOCAL UNION NO.	HOME TELEPHONE NUMBER				
	Claim Is For: <input type="checkbox"/> Self <input type="checkbox"/> Other	PATIENT'S NAME (First) (Last)		Patient's Relationship to Insured		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
	IS PATIENT A FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, name of school attending and city where school is located				Is insured and/or spouse eligible for Medicare or Champus? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	NAME AND ADDRESS OF PATIENT'S EMPLOYER					Does patient have group insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THIS CLAIM				PATIENT'S LOCAL UNION NUMBER	PATIENT'S SOC. SEC. NO.				
	DID PATIENT'S WORK CAUSE THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has a Claim been filed with the Worker's Compensation carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	FIRST DAY UNABLE TO WORK Date _____ Hour _____		<input type="checkbox"/> AM <input type="checkbox"/> PM	IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN				
	IF CLAIM IS FOR AN INJURY, COMPLETE THIS SECTION	DATE OF INJURY	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	WAS PATIENT AT WORK WHEN INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, for whom?						
		HOW DID INJURY HAPPEN?								
WHERE WAS THE PATIENT WHEN INJURED?										
The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, surgeon, practitioner or other person, any hospital, including Veteran's Administration or governmental hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A photostat of this Authorization shall be as valid as the original.										
Employee's Signature _____			Date Signed _____	Spouse's Signature _____						
PART 2	ASSIGNMENT OF BENEFITS (See Instructions before signing)		"I authorize payment of benefits directly to the person or organization named below, not to exceed the benefits otherwise payable to me for the services rendered." Date Signed _____ Employee's Signature _____		Administrative Use (Do Not Write In This Space)					
	JAN	JUL	FEB	AUG						
PART 3 ATTENDING PHYSICIANS STATEMENT REPORT OF SERVICES	1. PATIENT'S NAME		AGE	MAR	SEP					
	2. DIAGNOSIS AND CONCURRENT CONDITIONS		MAY	NOV	Date _____ Initials _____					
	3. IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		4. IS CONDITION DUE TO PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO		Hired _____ Term _____					
	APR	OCT	JUN	DEC						
	Date _____	Rate _____	Date _____	Initials _____	Hired _____					
	Term _____									
REPORT OF SERVICES	Date(s) of Service(s)	OFFICE	HOME	IN HOSP	OUTPAT	OTHER	Description of Surgical or Medical Services	CRVS Procedure Code(s)	Charge(s)	Adm. Use
5. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED							6. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION			
7. PATIENT WAS CONTINUOUSLY DISABLED (Unable to work) <input type="checkbox"/> YES <input type="checkbox"/> NO From _____ Through _____							8. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK			
9. DOES PATIENT HAVE OTHER HEALTH INSURANCE OR HEALTH PLAN COVERAGE? (If "Yes," please identify) <input type="checkbox"/> YES <input type="checkbox"/> NO										
PHYSICIAN'S NAME					DEGREE		SOC. SEC. NO. or TAX I.D.			
ADDRESS					CITY		STATE		ZIP CODE	
PHYSICIAN'S SIGNATURE					DATE		TELEPHONE NUMBER			