CLAIM MUST BE SUBMITTED TO THE FUND OFFICE WITHIN 90 DAYS

Submit to:

LOCAL 295/LOCAL 851

Employer Group Welfare Fund

60 Broad Street, 37th Floor
New York, N.Y. 10004
Telephone (212) 308-4200 Fax (212) 847-2426

Group Insurance
Medical Claim Form
212-308-4200

PLEASE PRINT

Section 1 to be Completed by Member

Please answer all questions.

Member's Last Name	First Name	Initial	Social Security No.	Date of Birth	Mo.	Day	Year

Address: No. & Street | City | State | Zip | Home Phone No. ( )

Name of Employer | Is member working? Yes ☐ No ☐ | Employer Phone No. ( )

IF CLAIM IS FOR SPOUSE OR CHILD

Name of spouse or child	Sex	Relationship to Member: Spouse ☐ Child ☐	Date of Birth	Mo.	Day	Year

Is spouse or child employed? Yes ☐ No ☐ If Yes, give name and address of employer

Do you, your spouse or your child have other group medical or hospital coverage? Yes ☐ No ☐ If Yes, give name of the Insurance Co. or Plan

Is treatment for condition caused by an injury? Yes ☐ No ☐ If Yes, Where? Auto Acc. ☐ At Work ☐ Other ☐ If other, describe

Date of Injury	Mo.	Day	Year

If this treatment is for **EMERGENCY ROOM** treatment, please give specific details regarding visit. _____

I authorize the physician and/or hospital to furnish Local 295/851 Employer Group Welfare Fund with information about my claim.

Member MUST sign here _____ Date _____

I AUTHORIZE PAYMENTS OF BENEFITS DIRECTLY TO THE PHYSICIAN OR OTHER PROVIDER OF SERVICE.

Member signs here if applicable _____ Date _____

Section 2 to be Completed by Practitioner

Name of **PATIENT** | Was patient referred to you by another physician? Yes ☐ No ☐ Name of referring physician:

DIAGNOSIS

Does condition or injury arise out of patient's employment? Yes ☐ No ☐ Pregnancy? Yes ☐ No ☐ **If yes, approximate date pregnancy commenced:** Date

Services: (please itemize or attach itemized bills)

DATES	PLACE (Office/Hospital/Other)	CPT Code	DESCRIPTION	CHARGE

Total Charges $ _____

Amount Paid $ _____

If service rendered in hospital, give: Name of Hospital | Date of Admission | Date of Discharge

Practitioner's Name & Address, Zip, Tel. No.

Taxpayer I.D. No. _____

Signature of Practitioner:

Specialty _____ (FILL IN **ONLY** IF BOARD CERTIFIED)

Signed: _____ Date: _____