

**Plumbers & Steamfitters Local 73
Health and Welfare Fund
P.O. Box 911, Oswego NY 13126
Phone (315) 343-1808**

PART A

MEMBERS STATEMENT

1. Employee's name Date of Birth
2. Social Security #
3. Address
4. If claim is for dependent, give name
Relationship of dependent to Employee Date of Birth
5. Date of accident or sickness Date last worked
 - a. Describe sickness or how injury occurred
 -
 - b. Were you working at the time (yes or no)
 - c. If yes, did you file a claim for Workmen's Compensation (yes or no)

PART B

TO BE COMPLETED BY PATIENT (INSURED)

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Patient's Name and Address _____ Date of Birth _____

Insured's Name If Patient is a Dependent _____

If Group Insurance, Name of Policyholder (i.e. Employer, Union or Association through whom insured)
Plumbers & Steamfitters Local 73 Health and Welfare Fund

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services. Signed (Insured Person) _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment. Signed (Patient, or Parent if Minor) _____ Date _____

PART C

ATTENDING PHYSICIAN'S STATEMENT*

1. **DIAGNOSIS AND CONCURRENT CONDITIONS**
(If Diagnosis Code other than ICDA* used, give name):

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? PREGNANCY? IF YES, APPROXIMATE DATE PREGNANCY COMMENCED.
Yes No Yes No Date _____

3. **REPORT OF SERVICES** (or attach itemized bill) (If previous form submitted to this carrier, you need show only dates and services since last report)

Date of Services	Place of Services†	Description of Surgical or Medical Services Rendered	PROCEDURE CODE — IF USED (If Code Other Than CPT** Used, Give Name)	Charges



- †O—Doctor's Office IH—Inpatient Hospital NH—Nursing Home
- H—Patient's Home OH—Outpatient Hospital OL—Other Locations
- *ICDA—International Classification of Diseases
- **CPT—Current Procedural Terminology (current edition)

Total Charges \$.....

Amount Paid \$.....

Balance Due \$.....

4. **DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED**

5. **PATIENT EVER HAD SAME OR SIMILAR CONDITION?**
Yes No If "Yes" when and describe:

6. **PATIENT WAS CONTINUOUSLY TOTALLY DISABLED** (Unable to work).

7. **IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.**
From _____ Thru _____

8. **DOES PATIENT HAVE OTHER HEALTH COVERAGE?**
Yes No If "Yes" please identify

9. **I DO NOT ACCEPT ASSIGNMENT.**

Taxpayer Identification applicable to above charges: _____ Social Security No. _____ Employer Identification No. _____

Date _____ Physician's Name (Print) _____ Signature _____ Degree _____ Telephone _____

Street Address _____ City or Town _____ State or Province _____ Zip Code _____