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? Yes ☐ No ☐ PREGNANCY? Yes ☐ No ☐ IF YES, APPROXIMATE DATE PREGNANCY COMMENCED. 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).
From Thru

7. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

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

*Physician: If above Authorization To Release Information is unexecuted refer to general authorization on other side.

Approved by Council on Medical Service, AMA 10-'67