UNITED PLANT AND PRODUCTION WORKERS LOCAL 175 WELFARE FUND

In Care of MagnaCare
1600 Stewart Ave, Westbury, NY 11590
Telephone: 866 624-6280

STATEMENT OF CLAIM FOR MEDICAL CLAIMS

CLAIM form to be completed by MEMBER

(Please Print ALL Answers)

1. Your Name _____ Age _____ Birth Date _____

2. Your Address _____ _____
   Nn. Street City State Zip Code

3. Social Security Number Telephone _____

4. Employed by (company name) _____

5. Are you or your dependents covered for benefits under any other Plan or Insurance? Yes ☐ No ☐

   If so, give name of Insurance Carrier or Plan _____

If this is a Claim for a DEPENDENT, fill in this section

6. Dependent's Name _____ Age _____ Birth Date _____

   Relationship _____ Sex _____

If this is a Medical Claim for the MEMBER, fill in this section

7. Date Last Worked _____ Date Disability Began _____ Date Returned To Work _____

8. Is Disability Due to Employment? Yes ☐ No ☐ Confined to Hospital? Yes ☐ No ☐

   Are you receiving wages for this period of disability? Yes ☐ No ☐

   Cause and Nature of Disability. If Accident WHEN, WHERE AND HOW did it occur? _____

   _____

9. Have you previously been treated for this or a related medical problem? Yes ☐ No ☐ If yes, state when and where and give name(s) and address(es) of doctor(s) and hospital(s) _____

   _____

I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by the Local 175 Welfare Fund or its representatives. A photo static copy of this authorization shall NOT BECONSIDERED VALID.

Patient's Signature if claim is for dependent other than minor child

Date _____ **Signature of MEMBER** _____

To Authorize payment of benefits directly to your physician for a Medical Claim, complete authorization to pay benefits section on reverse side.

PLEASE ATTACH ITEMIZED BILL FOR MEDICAL CLAIM

CERTIFICATE OF ATTENDING PHYSICIAN OR SURGEON

(Please fill in all dates)

1. I certify I attended _____ _____
(Name of Patient)

2. Age of Patient _____ Date of First Treatment For Present Disability _____ Where _____
3. Diagnosis (legible please) _____
4. In your opinion is disability due to an illness or injury arising out of patient's employment? Yes ☐ No ☐
If "Yes", please explain _____
_____
5. Is disability a result of pregnancy? _____

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

Date of Services	Place of Services	Description of Surgical or Medical Services Rendered	CPT PROCEDURE CODE	Charges
			Total Charge	$
		+ -Doctor's Office IH-Inpatient Hospital NH-Nursing Home H-Patient's Home OH-Outpatient Hospital OL-Other Locations ***CPT-Current Procedural Terminology (current edition)	Amount Paid	$
			Balance Due	$

7. Name and address of hospital _____ _____
Date admitted _____ Date Discharged _____
8. If surgery was not performed by you, give name and address of surgeon
_____
9. Are further treatments necessary? _____ Is this *your* final bill? _____
10. This patient was under my care, continuously disabled and unable to work from _____ to _____
11. This patient should be physically able to return to work on.
12. Additional remarks _____
13. Name (Please Print) _____ M.D. TAX I.D. OR Social Security No. ☐☐ ☐☐ ☐☐☐☐
Address _____
14. Date _____ Signed _____
(Signature of Doctor Only)

Make Payment DIRECTLY to the PROVIDER

_____
Signed

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.

_____ Date _____

Signed by Member

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my examination or treatment.

_____ Date _____

NOTE: NO ASSIGNMENT HONORED UNLESS DOCTOR'S TAX I.D. OR SOCIAL SECURITY NUMBER IS ENTERED ABOVE