UNITED FOOD AND COMMERCIAL WORKERS LOCAL NO. 1529 AND EMPLOYERS HEALTH AND WELFARE PLAN AND TRUST

661 N. Ericson Rd, Cordova TN 38018
1-800-874-8499

HOW TO FILE A MEDICAL CLAIM FORM:

1.) Complete all sections of the form
2.) If you are filing several bills for the same diagnosis on the same person, you may attach all related bills to one claim form. WE DO NOT ACCEPT RECEIPTS OR CANCELLED CHECKS.
3.) The bills must be itemized. Itemized means the physician and the hospital must have their address, tax ID, date of service, amount charged etc.
4.) We will accept “super bills” provided you have attached our claim form that you have completed to that billing.
5.) All claims must be filed within 12 months from the date of service.

To avoid delay – complete ALL sections in their entirety.

Section I: Patient and Employee Information:

Medical Expenses on this form were incurred by: ____SELF ____Dependent

Policy Holder’s Name: __________________________ Policy Holder’s ID #: ___________________

Patient’s Name (if different) _______________________ Patient’s ID#: ___________________

Did this injury occur at work? ____YES ____NO

Other Group Coverage Information:

Does the patient have any other insurance coverage? ____YES ____NO

Address: ____ Phone #: ________________

Section II: If “YES” please provide the following information:

Name of insurance company:_________________________ Policy Holder’s Name: ___________________

Group Number: _____________ Policy #:__________________ Effective Date: ________________

UNITED FOOD AND COMMERCIAL WORKERS LOCAL NO. 1529 AND EMPLOYERS HEALTH AND WELFARE PLAN AND TRUST
661 N. Ericson Rd, Cordova TN 38018
1-800-874-8499

Section III: Claim and Physician Information:

Line Item	*Place of Service Code	Procedure Codes	Diagnosis Codes	Line Item Charge	Total Charges	Amount Paid	Balance Due
1				$	$	$	$
2				$	Place of Service Codes: (IH)-Inpatient (OH)-Outpatient Hospital (0)-Doctor's Office (H)-Patient's Home (PSY)-Day or Night Care Facility (NH)-Nursing Home (SNF)-Skilled Nursing Facility (IL)-Independent Laboratory Ambulance Other		
3				$			
4				$			
5				$			
6				$			
7				**$**			

Facility/Clinic Name: ___________________________________
Treating Physician's Name:______________________________
Physician Physical Address:____
Physician Billing Address: ____
Physician's Tax ID Number: ___-________________
(If the physician in out of network, a copy of their most recent W-9 must be attached)

Section IV: Signatures

Physician's Signature: ____ Date: ______________

Patient's Signature:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the medical services as described, but not to exceed the reasonable and customary charge for those services.	**SIGNED:** **DATE:**
AUTHORIZATION TO RELEASE INFORMATION: I hereby certifiy that the above statements are true, correct and complete to the best of my knowledge and belief and I authorize any hospital, physician, or insurance company to disclose any knowledge or information concerning this or other disabilities. A photocopy of this authorization shall be valid as an original.	**SIGNED:** **DATE:**

If reimbursement is to be made to the patient please include a copy of the receipts of payment for the services.