# Sheet Metal Workers' Health Plan

## Of Southern California, Arizona and Nevada

P.O. Box 10067
Manhattan Beach, CA 90266-8567
Phone: (310) 798-6572 or (800) 947-4338
Fax #: (310) 798-0766

**MEDICAL EXPENSE CLAIM FORM**

**MAIL COMPLETED FORM AND ALL BILLS TO PLAN OFFICE**

## EMPLOYEE'S STATEMENT

| Social Security Number or SM1 #: | Name (Last Name First) | | | | Local Union No. |
|---|---|---|---|---|---|
| Address: Street | City | State | Zip | | Phone |
| Patient's Name | Male ☐ Female ☐ | Date of Birth | | | If Dependent, Relationship |
| Patient's Address | | Month | Day | Year | Dependent's Occupation |

**Is the Patient covered under any other group plan that provides benefits for this disability?** ☐ YES ☐ NO **If yes, is the entire cost paid by an employer?** ☐ YES ☐ NO

**Does the dependent child reside with you?** ☐ YES ☐ NO **If step-child does natural mother have Group Insurance?** ☐ YES ☐ NO

**Is the patient covered under Medicare?** ☐ YES ☐ NO **If yes effective date** _____ **and attach Medicare Explanation of Benefits.**

**Dependent's Employer** _____

**Dependent's Social Security No.** _____

**Name of Company providing benefits for Dependent** _____ **Policy No.** _____

**Address** _____

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**Is disability due to patient's occupation?** ☐ YES ☐ NO **Employed by** _____

**If "Yes", has patient filed or does he intend to file a claim for Workmen's Compensation?** ☐ YES ☐ NO

**First full day unable to work** _____ **Date resumed work** _____ **Date expected to resume work** _____

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**Is patient's condition due to an accident or injury?** ☐ YES ☐ NO **If yes, when** _____ **20**____ **at** _____ ☐ **AM** ☐ **PM**

**Describe accident or injury and how and where it occurred?**

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**I hereby certify that the foregoing statements including any accompanying statements are true, correct and complete to the best of my knowledge and hereby authorize the attending physician or practitioner, and the hospital in which confinement took place. If any, to furnish and disclose all records and information concerning the patient's physical condition that are within their control or knowledge.**

**I further authorize, on behalf of myself and my dependent, if any, Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada to use or disclose any information contained in its file in whatever manner it deems necessary for the purpose of determining the reasonableness of any of the expenses submitted herewith or the propriety of this claim.**

**DATE SIGNED** _____ **EMPLOYEE'S SIGNATURE** _____

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**IMPORTANT**

1. **Employee must sign claim form.**
2. **Answer ALL questions on this statement. Do not return until physician has completed reverse side.**
3. **If this claim is for a dependent, an enrollment card listing such dependent must be on file in the Plan Office before claim can be processed.**
4. **If payment is to be made to Physician, Employee must sign Authorization in reverse side.**
5. **The furnishing of this form is not an admission of liability by the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada nor waiver of any of its rights or defenses.**

**I/We also authorize any Union, Trust Fund or Insurance Carrier to furnish the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada with information regarding benefits to which I/we may be entitled. (If claim for spouse, spouse must also sign)**

_____ _____ _____

**Date** **Dependent's Signature** **Employee Signature**

## PHYSICIAN'S STATEMENT

| Patient's Name (Last Name First) | Male ☐ Female ☐ | Relationship to Employee | Age |
|---|---|---|---|
| | | | |

**Diagnosis (Describe Complications, if any)**

**Is Disability due to Patient's Occupation?** ☐ YES ☐ NO **If yes, Explain**

**Cause of Disability**

**Accident** ☐ **Sickness** ☐ **Pregnancy** ☐

**If Pregnancy, list date of L.M.P.** _____

**If Accident, date of accident** _____ **How and where did it occur, as indicated in your records?**

## SURGERY SERVICES

| Nature of Surgery or Obstetrical Procedure (described in detail) CPT _____ | Date of Surgery |
|---|---|
| | Fee for Surgery |

## NON-SURGERICAL SERVICES

| Date and Place | | | | | Describe each service (Examination. Treatment, X-ray, Etc.) | Fee Charged |
|---|---|---|---|---|---|---|
| Date | Home | Hospital | Office | RVS = | | |
| | | | | | | |

| If Hospitalized, Name of Hospital | Admission Date | Dismissal Date and Hour |
|---|---|---|
| | | |

| Date Patient returned to work | If Patient still disabled, approximate date of release for work |
|---|---|
| | |

**Is Patient covered by any other Health Coverage?** ☐ YES ☐ NO **Give Name, address and Policy Number of other carrier** _____

_____.

**Is Patient entitled to Medicare?** **PART A** ☐ YES ☐ NO **PART B** ☐ YES ☐ NO

**I hereby authorize the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada or its representatives to examine all medical records pertaining to the disability of the above-named patient.**

**DATE SIGNED** _____ **PHYSICIAN'S SIGNATURE** _____

| Address of Physician | Phone Number Area _____ | Please Print or Type Physician's Name and Tax I.D. No. |
|---|---|---|
| | | Please Indicate Amount Paid $ |

### EMPLOYEE'S AUTHORIZATION

**The undersigned hereby authorizes Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada, to pay whatever medical or surgical benefits may be due the undersigned under the terms of the Medical Plan, (except Hospital) by check drawn to the order of the physician or surgeon indicated hereon to the extent of the physician's or surgeon's charges herein or by statement attached.**

**DATE SIGNED** _____ **EMPLOYEE'S SIGNATURE** _____