Medical/Dental/Vision Claim Form

# IDAHO PIPE TRADES HEALTH AND WELFARE TRUST

A Self-Funded Health Plan


## 575 N Ralstin St, Suite B, Meridian, ID 83642

## 208-288-1610 Fax 208-288-1670


**Instructions:**
Complete this form, attach all itemized bills, send to the plan administrator at the address above, & keep a copy for your records.

**For Assistance Nationwide Call:**
**Idaho Pipe Trades Trust Claims Office**
**1-800-808-1687**

**PART I – TYPE OF CLAIM:** Check type(s): ☐ Medical ☐ Dental ☐ Vision

**PART II – EMPLOYEE DATA:**

Employee Name: ________________________________________ Member Cert #: ________________
*(First Name)* *(Last Name)*

Mailing Address: ____________________________________________________________
*(Street)* *(City)* *(State)* *(Zip)*

**PART III – PATIENT DATA:** Claim is for: ☐ Employee ☐ Spouse ☐ Dependent Child

Patient Name: ________________________________________ Birth Date:_______/_______/_______
*(First Name)* *(Last Name)*

If child is age 19 or older, is child a full-time student? ☐ Yes ☐ No
If Yes, current semester enrollment form must be on file

If No, does child have a developmental disability, physical handicap, or live at home? ☐ Yes ☐ No

If claim is for dependent child, indicate relationship:
☐ Child ☐ Step Child
☐ Other__________________________________

**PART IV – OTHER INSURANCE INFORMATION:**

Does patient have other health insurance coverage: ☐ Yes ☐ No If yes, please complete the following for each policy/plan:
Insurance company/plan administrator's name, address, telephone #, policy/plan #, and types of coverage:

1.________________________________________________________ ☐ Medical ☐ Dental ☐ Vision

2. ________________________________________________________ ☐ Medical ☐ Dental ☐ Vision

Is spouse employed? ☐ Yes ☐ No If yes, please write name, address and telephone number of employer:

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**PART V – CLAIM INFORMATION (complete only applicable information):**

Are expenses related to an accident? ☐ Yes ☐ No If yes, indicate date of accident _______/_______/_______ and type of accident:

☐ Automobile

☐ Employment-Related: Name, address & telephone # of employer:____________________________________________

☐ Home/Recreational ☐ Other ____________________________________________

Briefly describe accident: ____________________________________________

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*Note: If claim is related to an accident, you will receive an "accident questionnaire". Respond promptly to expedite claim processing.*

**PART VI – AUTHORIZATION TO PROCESS CLAIM:**

In order to process a claim for benefits, I authorize any physician, hospital, or other medical provider to release to Idaho Pipe Trades Health and Welfare Trust and the planholder, or their representatives, any information regarding my and/or my dependent's health history, symptoms, treatment, examination results or diagnosis. This authorization shall be considered valid for the duration of the claim. ***Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.***

I AUTHORIZE BENEFIT PAYMENT TO THE HEALTH PROVIDER FOR THE SERVICES AND/OR SUPPLIES DESCRIBED ON THIS CLAIM FORM. ☐ Yes ☐ No

________________________________________ _______/_______/_______
Eligible Participant's Signature Date

## ATTENDING PHYSICIAN'S STATEMENT

| PATIENT'S NAME | | | AGE |
|---|---|---|---|
| DIAGNOSIS AND CONCURRENT CONDITIONS | | | |
| IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? | | YES ☐ | NO ☐ |
| COMPLETE REPORT OF SERVICES OR ATTACH AN ITEMIZED BILL IF A PREVIOUS FORM HAS BEEN SUBMITTED, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT | | | |
| DATE OF SERVICES | DESCRIPTION OF SERVICES RENDERED | PROCEDURES CODE | CHARGES |
| | | | |
| | | | |
| | | TOTAL CHARGES | $ |
| | | AMOUNT PAID | $ |
| | | BALANCE DUE | $ |

| | |
|---|---|
| DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED | DATE PATIENT FIRST SEEN FOR THIS CONDITION |
| PATIENT EVER HAD SAME OR SIMILAR CONDITION?<br>YES ☐ NO ☐ IF "YES", WHEN AND DESCRIBE: | PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?<br>YES ☐ NO ☐ |
| DOES PATIENT HAVE OTHER HEALTH COVERAGE?<br>YES ☐ NO ☐ IF "YES", PLEASE IDENTIFY | |

| DATE | PHYSICIAN'S NAME (PRINT) SIGNATURE | DEGREE | TELEPHONE |
|---|---|---|---|
| | | | |
| STREET ADDRESS | CITY-STATE-ZIP CODE | INDIVIDUAL PRACTITIONERS TIN OR SS# | |

### PROCEDURE FOR FILING A CLAIM

1. Complete all applicable sections of the "Employee Statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim.
2. Attach an itemized bill or prescription receipts for all charges related to this claim.
3. Complete a separate form for each patient.
4. Mail completed form and itemized bills to: Idaho Pipe Trades Health and Welfare Trust<br>575 N Ralstin St., Suite B<br>Meridian, ID 83642

To ensure prompt payment submit only itemized bills. An itemized bill is the actual bill from the provider showing: a) date of service; b) diagnosis; c) procedure done and d) cost of each procedure. A "balance due" or non-itemized bill is NOT acceptable.

If you have other Group Insurance or Medicare as your primary coverage you need to submit the itemized bill AND a copy of the matching Medicare or other insurance payment explanation of benefits.