Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109-4318
860-571-9191

Group #10777

STATEMENT OF CLAIM
FOR MEDICAL EXPENSE BENEFITS

▲ **Do Not Write Above This Line**

Member's Statement

Answer all questions below omitted information will cause delays.

Name (print) First	Middle	Last	Social Security Number	Date of Birth	☐ Male ☐ Female
			/ /		

Present Address: Street	City	State	Zip Code	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Phone No. (Include Area Code) ( )

Dependent Information - Complete this section only if expenses were incurred by an eligible dependent or dependents.

Name (print) First	Middle	Last	Social Security Number	If Age 19 or over ☐ Student ☐ Disabled If Student, Name of School & City
			/ /	

Date of Birth	Relationship	☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married

Family Employment - Complete this section only if other members, including dependent minors, are employed.

Name of Family Member (print) First	Middle	Last	Relationship	Date of Birth	Employer's Phone No. (Include Area Code) ( )

Employer's Name (print)	Employer's Address - Street	City	State	Zip Code

Accident Information - Complete this section only if claim is result of accidental injury or occupational sickness.

Date of Accident	Time of Accident : ☐ A.M. ☐ P.M.	Where Did the Accident Occur? (City/State)	Did the Accident/Sickness Happen at work? ☐ Yes ☐ No

Describe Accident or Occupational Sickness:

Medicare Information - Complete this section only if Patient is eligible for Medicare.

Please Attach a Copy of the "Explanation of Benefits" Statement From Your Medicare Insurance Carrier.	Medicare	Part A	Effective Date	Part B	Effective Date

Other Coverage Information - This section must always be completed.

Are any benefits or services provided under another group insurance plan or any prepayment plan, or pursuant to any law (Federal, State, or Local) on account of the treatment reported on this claim?

☐ Yes ☐ No

If "Yes", answer (A) or (B), whichever applies, and (C).

A. Other Insurance Coverage is: ☐ Group ☐ Individual ☐ H M O
☐ Other (specify) ➤

B. Name or Type of Law (e.g., Medicaid, Champus, No-Fault)

C. Give Name and Address of Other Company or Organization Providing Benefits of Services.

Name

Address

City State Zip Code

Please Indicate Plan Identification No. or Blue Cross/Blue Shield Group No.(s). ➤

Itemized Bills - Attach itemized bills for expenses not reported on this form. All such miscellaneous bills must show:

a. Employee's Name b. Patient's Name (if not employee) c. Name and Address of Provider of Services d. Diagnosis
e. Complete Description of Services Rendered f. Initials of Attending or Prescribing Physician g. Dates (month, day, year) of Service.

Medical Authorization

- **I authorize** any insurance company, organization, employer, hospital, physician or pharmacist to release any information requested with regard to this claim and the expenses reported.
- **I certify** that the information I furnish in support of this claim is true and correct.
- **I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.**

Signed (Employee, who must sign for all claims)

Date

Signed (Dependent patient who is not a minor)

Date

Payment of Benefits - Check all appropriate boxes before signing.

- Except where my plan provides for automatic payment of benefits to the provider(s) of services, I **authorize** payment of benefits provided by the group plan directly to:

  Hospital ☐ Yes ☐ No Surgeon/Physician ☐ Yes ☐ No

- **I understand** that:
  - Unless I have checked "Yes" above, benefit payments will be paid to me.
  - Even if I have checked "Yes" above, I may still be responsible for any amounts not paid by the group plan.

☐ The provider **has not** agreed to waive the group plan deductible or copayments and will bill the patient for them.
☐ The provider **has agreed** to waive the group plan deductible or copayments.

Authorizations will be honored only if a valid Tax Identification or Social Security Number for the provider is shown on the claim form.

Signed (Employee)

Date

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Hospital Statement

Attach a copy of the hospital bill or statement. Fill in the following only if the bill or statement does not contain the information requested below.

Name of Patient	Age	Date Admitted	Time Admitted : ☐ A.M. ☐ P.M.	Date Discharged	Time Discharged : ☐ A.M. ☐ P.M.

If Patient Had Other Than Semi-Private Room, Indicate Most Common Semi-Private Rate $	Other Insurance Indicated By Hospital Records? ☐ Yes ☐ No	Name of Company	Amount Paid $

ICD-9 Code	Diagnosis From Records (If injury, give date and place of accident)

Operations or Obstetrical Procedures Performed (Nature and date)	Taken from Records on

Hospital	Address

☐ **We will not** waive the group plan deductible or copayments and will bill the patient for them.
☐ **We will** waive the group plan deductible or copayments.
Signed

I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Date

Phone No. (Include Area Code) ( )

Provider ID No. /

Physician's/Surgeon's Statement

Patient's Name (First name, middle initial, last name)	Patient's Date of Birth

Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	Date the Patient First Consulted You for this Condition	Has Patient Ever Had Same or Similar Symptoms? ☐ Yes ☐ No

Name & Address of Referring Physician

For Services Related to Hospitalization, Give Hospitalization Dates	Date Admitted:	Date Discharged:	Was Laboratory Work Performed Outside Your Office? ☐ Yes ☐ No	Charges $

Name & Address of Facility Where Services Were Rendered (if other than home or office)

If Anesthesia Was Administered, Give Date	Duration of Anesthesia Hours: Min.:	Do you Consider the Injury or Sickness Work Related? ☐ Yes ☐ No

If Patient Has Additional Coverage, Please Identify

Diagnosis or Nature of Illness or Injury

1.
2.
3.
4.

Relate Diagnosis to Procedure in this Column by Reference to Numbers 1, 2, 3, Etc.

Place of Service *	Fully Describe Procedures, Medical Services or Supplies Furnished For Each Date Given: CPT-4 Procedure Code Identity	(Explain Unusual Services or Circumstances)	ICD-9 Diagnosis Code	Charges	Date Of Service	Amount Paid
				$		
				$		$
				$		
				$		Balance Due
				$		
				$		$

Your Patient's Account No.	Total Charge $

Physician's/Surgeon's Name	Address	Phone No. (Include Area Code) ( )

☐ **I will not** waive the group plan deductible or copayments and will bill the patient for them.
☐ **I will** waive the group plan deductible or copayments.
Signed

I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Date

Social Security No. / /

Provider ID No. /

Authorizations will not be honored if your Social Security or Tax Identification number is not shown above.

* Place of Service Codes (H) - Hospital (inpatient) (X) - Hospital (outpatient) (O) - Office (E) - Elsewhere (M) - Home (D) - Daycare (K) - Nightcare (C) - Convalescent Facility (A) - Ambulatory Surgicenter