BAC Local Union 15 Welfare Fund

INITIAL REPORT OF CLAIMS

NO BENEFITS CAN BE PAID UNLESS THIS FORM IS COMPLETED IN ITS ENTIRETY

INSTRUCTIONS:

This form is to be completed by the member. Complete member's section fully. Be sure to include your Social Security Number and sign member's signature section. Remember to attach itemized bills.

RETURN COMPLETED FORM TO:

BAC Local Union 15 Welfare Fund
PO Box 909500
Kansas City, MO 64190-9500
(816) 777-2668 | Fax: (816) 756-3659

MEMBER COMPLETES THIS SECTION:

Name of Member		Home Phone	
Date of Birth	Social Security Number	Occupation	
Employer			
Home Address	City	State	Zip Code
If claims is for member's disability, show date last worked:		Date resumed work:	

COMPLETE THIS SECTION FOR ALL CLAIMS:

Nature of Sickness or Injury:	Date Accident Occurred or Sickness Began:	Date First Treated:
If Hospitalized, Name of Hospital:	Date Admitted:	Date Discharged:

Did someone intentionally cause this injury? ☐ YES ☐ NO | Was injury due to an accident? ☐ YES ☐ NO

Did the accident happen on your property? ☐ YES ☐ NO If no, address where accident occurred:

Was this due to an auto accident? ☐ YES ☐ NO | Did injury or illness occur in the course of employment? ☐ YES ☐ NO

Have you filed this claim under Workmen's Compensation? ☐ YES ☐ NO

Have you started a lawsuit related in any way to this injury/illness? ☐ YES ☐ NO

Have you received any settlement, payment, recovery of benefits, including insurance company policy, related in any way to this injury/illness? ☐ YES ☐ NO

Are you an owner or officer of your employer? ☐ YES ☐ NO

Are you receiving accident/sick pay from your employer? ☐ YES ☐ NO

Have you hired an attorney to represent you regarding this claim? ☐ YES ☐ NO

I hereby make claim for benefits and certify that the above statements are true and correct to the best of my knowledge and belief. I authorize the above named institution or physician to release information concerning my enrollment, related records and medical records to the BAC Local Union 15 Welfare Fund.

Insured Member's Signature _____ Date _____

INSTRUCTIONS:

ATTENDING PHYSICIAN'S STATEMENT

This form does not have to be completed, **if** you can furnish the Administrator with a complete itemized and coded statement of services from the doctor. If you do not have a complete itemized and coded statement, your physician may use this form to report his/her services and charges.

DISABILITY

To collect disability benefits, your physician must complete questions, 1, 2, 4, 5, 7, 8, 9 and sign and date this form. If you are unable to work due to a work related disability that occurred while you were working in the jurisdiction of BAC Local Union 15, you must submit evidence (such as check stubs) that you are receiving weekly disability benefits from Worker's Compensation. You will be credited with 30 disability hours for each full week of disability.

ATTENDING PHYSICIAN'S STATEMENT:

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA used, give name).

2. Is the condition due to injury or sickness arising out of patient's employment?

Is condition due to pregnancy? If yes, approximate date pregnancy commenced.
☐ YES ☐ NO

3. Report of services (or attach itemized bill. If previous form submitted to this carrier, you need show only dates and services since last report).

Date of Services	Place of Services	Description of Surgical or Medical Services Rendered	Procedure code - If used If code other than CPT used, give name	Charges	**Office Use Only**

+O = Doctor's Office IH = Inpatient Hospital
H = Patient's Home OH = Outpatient Hospital
NH = Nursing Home OL = Other Location
ICDA = International Classification of Diseases
CPT = Current Procedure Terminology (current location)

Total Charges $_____
Amount Paid $_____
Balance Due $_____

4. Date symptoms first appeared or accident happened.

5. Date patient first consulted you for this condition.

6. Has patient ever had same or similar condition? if yes, when and describe. ☐ YES ☐ NO

7. Is patient still under your care for this condition?
☐ YES ☐ NO

8. Patient was continuously totally disabled (unable to work).
From: Thru:

9. Date patient should be able to return to work, if still disabled.

10. Does patient have other heath coverage? If yes, please identify
☐ YES ☐ NO

Taxpayers identification number:

Print Physician's Name	Physician's Signature	Degree	Date

Street address

Telephone

City	Providence	State	Zip Code

MEMBERS ASSIGNMENT (PLEASE READ BEFORE SIGNING)

To be completed and signed by the Member if direct payment by fund to surgeon or physician is desired. (This assignment may not be honored if signed by a dependent or person other than the Insured Member).

I hereby authorize the BAC Local Union 15 Welfare Fund to pay directly to the above named hospital or physician the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Group Policy.

Insured Member's Signature _____ Date _____