# WASHINGTON WHOLESALERS HEALTH AND WELFARE FUND

## 7130 Columbia Gateway Drive, Suite A, Columbia, Maryland 21046

(410) 872-9500

ATTENDING PHYSICIAN MUST COMPLETE REVERSE

**This Side To Be Completed By Employee** (Please Print Clearly)

Name and Home Address of Employee (Print)
Mr.
Mrs.
Miss _____

Member of Local Union No. _____

Soc. Sec. No, _____

No. Street City State Zip

Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Legally Separated

Date of Birth _____
Month Date Year

**Dependent's Information:** (Complete Only If Claim Is For Dependent)

| Name of Dependent | Date of Birth | Relationship | Marital status if other than spouse |
|---|---|---|---|
| | | ☐ Wife ☐ Husband ☐ Child<br>☐ Other..... (Relationship) | ☐ Single ☐ Married ☐ Widowed<br>☐ Divorced ☐ Legally Separated |

**List All Employers During Past Three Months: Start with Present**

| Employer Name, City and State | Local No. | From | | To | |
|---|---|---|---|---|---|
| | | Yr | Mo. | Yr. | Mo. |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

**Nature of Illness or Disability**

Date you last worked Due to illness:
_____
Month Day Year

Cause of Disability: _____

If disability is due to an accident, state when, where and how it happened _____

Was illness or injury due, in any way, to your occupation?
☐ Yes ☐ No if "YES" Explain _____

Date returned to work
_____
Month Day Year

If you have filed for "Workmen's Compensation", complete the following
Claim No. Ins. Company Name and Address
Date Filed:
Month Day Year

**Other Group Health Coverage**

Is the person for whom claim is being made covered under any other group plan providing health benefits and/or Medicare? YES ☐ NO ☐
If YES", complete the following

(a) Person in whose name this other plan is carried _____

(b) Name of Employer _____

(c) Address of Employer _____

(d) Name of insurance company or organization providing benefits _____

(e) Address _____ Policy Number _____

**Authorization and Certification**

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release any and all information with respect to this claim which may be necessary to determine any amount payable. I certify that the above statements and information are correct.

Signed at _____ on _____ _____
City and State Mo. Day Yr. Signature of Employee

**If you wish payment to go directly to the Doctor, carefully read and complete the following. Otherwise, furnish PAID RECEIPTS.**

Assignment:
I hereby authorize payment directly to the physician of any benefits otherwise payable to me for services as described on reverse, but such payment shall not exceed the maximum allowable for such services I fully understand that I am financially responsible for all charges not covered by this Plan.

_____ _____
Mo. Day Yr. Signature of Employee

## ATTENDING PHYSICIAN'S STATEMENT

*Spaced for Typewriter—Marks for Tabular Appear on this Line*

| PATIENT'S NAME AND ADDRESS | SOCIAL SECURITY NUMBER | AGE |
|---|---|---|
| | | |

INSURED'S NAME IF PATIENT IS A DEPENDENT

| | | | |
|---|---|---|---|
| 14. DATE ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) | 15. DATE FIRST CONSULTED YOU FOR THIS CONDITION | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS'? YES ☐ NO | 16a. IF AN EMERGENCY CHECK HERE. ☐ |
| 17. DATE PATIENT ABLE TO RETURN TO WORK | 18. DATES OF PARTIAL DISABILITY FROM THROUGH | DATES OF PARTIAL DISABILITY FROM THROUGH | |
| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency) | | 20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED | |
| 19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency) | | 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO CHARGES | |
| 23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COL. D BY REF. NO. 1, 2, 3, ETC. or DX CODE<br>A<br>1<br>2<br>3<br>4 | | 10. WAS CONDITION RELATED TO<br>A. PATIENTS EMPLOYMENT<br>YES ☐ NO CHARGES<br>B. ACCIDENT<br>AUTO ☐ OTHER | |

| 20. A DATE OF SERVICE | B PLACE OF SERVICE | C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN<br>PROCEDURE CODE (IDENTIFY ) | (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) | D. DIAGNOSIS CODE | E. DAYS CHARGES | F OR UNITS | G T.O.S. | H. LEAVE BLANK |
|---|---|---|---|---|---|---|---|---|
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|---|---|---|---|---|
| 17. DATE PATIENT ABLE TO RETURN TO WORK<br>SIGNED DATE | 26. HAS BILL BEEN PAID?<br>IF YES, PAID RECEIPTS MUST BE FURNISHED<br>YES ☐ NO<br>30. YOUR SOCIAL SECURITY NO. | 27. TOTAL CHARGE | 28. AMOUNT PAID | 29. BALANCE DUE |
| | | 31. PHYSICIANS OR SUPPLIERS NAME, ADDRESS, ZIP CODE & TELEPHONE NO. | | |
| 32. YOUR PATIENTS ACCOUNT NO. | 33. YOUR EMPLOYER I.D. NO.<br>I.D. NO. | | | |