MEDICAL CLAIM FORM

CAREFIRST BLUE CROSS PHYSICIANS
MAIL CLAIM FORM TO:

CAREFIRST BLUE CROSS
P.O. Box 10104
Fairfax, VA 22038-8004
1-888-444-8115

NON CO-PAYMENT
Group # W32D

LOCAL #5
PLUMBERS & PIPEFITTERS
MEDICAL FUND

NON-CAREFIRST PPO PHYSICIANS
MAIL CLAIM FORM:
PLUMBERS AND PIPEFITTERS
MEDICAL FUND
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
1-800-741-9249

INSTRUCTIONS: This form is to be used to submit a claim for service covered under your plan. To avoid having your claim returned, please be sure all information is correct and complete. **IMPORTANT** - If a member is unable to work due to a non-occupational illness or injury, a special form must be submitted to claim weekly accident and sickness benefits.

PLEASE PRINT OR TYPE

THIS SIDE OF FORM IS TO BE COMPLETED BY MEMBER

1. Member's Name _____ Social Security No. _____
   Last *First* *Initial* Home Telephone No. _____

2. Home Address _____
   Street Number and Name *City* *State and Zip Code*

3. Name of Member's Employer _____ Employer's Telephone Number _____

4. Patient's Name _____ Patient's Sex ☐ Male ☐ Female Birth Date ____/____/____ *Month Day Year* Relationship To Member ☐ Self ☐ Child ☐ Spouse

5. Symptoms of illness or Injury requiring treatment _____

6. Was the treatment required as a result of an accidental injury? ☐ Yes ☐ No If Yes, complete the following:

   Date of injury _____ Place of injury _____

   How injury occurred _____

7. Is patient covered under other insurance offering benefits for Hospitalization, Surgical or Medical Expenses? ☐ Yes ☐ No
   If Yes, complete the following:

   Name of Insured _____ Name of Insurance Co. _____

   Address of Insurance Co. _____ Policy, Contract , or Identification Numbers _____

8. Is patient covered under Medicare? ☐ Yes ☐ No If Yes, attach form from Medicare carrier which explains benefits paid by Medicare.

9. Was illness or injury caused by employment? ☐ Yes ☐ No If Yes, do not submit claim to Medical Fund. Submit it to Workers Compensation Insurance Company.

10. Do you wish payment to be made directly to the Physician? ☐ Yes ☐ No

11. I certify that the above information is correct and that I have coverage with the Medical Fund. I apply for benefits under this coverage and authorize any physician, nurse, hospital, or other providers or suppliers in possession of information concerning the patient to furnish such information to the Medical Fund upon request.

    Date _____ Signature of Member _____

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

Have you completed form in full?

ATTACHED NECESSARY MEDICARE EXPLANATION OF BENEFITS STATEMENTS
ATTACHED NECESSARY STATEMENT ON OTHER INSURANCE PAYMENTS

THIS SIDE OF FORM IS TO BE COMPLETED BY PHYSICIAN

Name of Patient _____ Age _____

1. Diagnosis _____

2. Are treatments or services a result of:
   ☐ Illness ☐ Accidental Injury ☐ Routine Physical Examination

3. Was illness or injury caused by employment? ☐ Yes ☐ No

4. Report of services *(Or attach itemized bill) (If previous form submitted to Fund Office, 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*

†O - Doctor's Office IH - Inpatient Hospital NH - Nursing Home
H - Patient's Home OH - Outpatient Hospital OL - Other Locations
**ICDA - International Classification of Diseases
**CPT - Current Procedural Terminology (current editor)

Total Charges $ _____

Amount Paid $ _____

Balance Due $ _____

5. Date symptoms first appeared or accident happened _____

6. Date patient first seen for this condition _____

7. Has patient ever had related condition? ☐ Yes ☐ No If Yes, give details below:

_____

8. Is patient still under your care for this condition? ☐ Yes ☐ No

9. Date patient was unable to work from _____ thru _____

10. Referring Physician _____

11. Is patient covered under any other Health Benefits Plan? ☐ Yes ☐ No If Yes, please identify below:

12. Physician's Name _____ Provider's Tax ID or Social Security Number _____

13. Address _____
Street Number and Name *City* *State and Zip Code*

Date _____ Signature of Physician _____