

Medical / Dental / Vision / Prescription / Weekly Disability Claim Form

**NORTHWEST PLUMBING AND PIPEFITTING INDUSTRY
HEALTH AND WELFARE TRUST**

A Self-Funded Health Plan

P. O. Box 34203, Seattle, WA 98124-1203

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:
Welfare & Pension Administration Service
Claims Office 1-800-331-6158**

PART I - TYPE OF CLAIM: Check type(s): Medical Dental Vision
 Prescription Weekly Disability

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 Legal Guardianship
 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:

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: _____

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 Welfare & Pension Administration Service, Inc. (WPAS) 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 <input type="checkbox"/> NO <input type="checkbox"/>			
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			\$
THIS AREA MUST BE COMPLETED BY THE ATTENDING PHYSICIAN IF APPLYING FOR WEEKLY DISABILITY BENEFITS			
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED		DATE PATIENT FIRST SEEN FOR THIS CONDITION	
PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES", WHEN AND DESCRIBE:		PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) GIVE DATES FROM _____ THRU _____		LAST DAY WORKED	
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK		DATE EMPLOYEE RETURNED TO WORK	
DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/> 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. **If claim is for disability, a doctor MUST complete the "Attending Physician's Statement" shown above.**
3. Complete a separate form for each patient.
4. Mail completed form and itemized bills to:

NW Plumbing and Pipefitting Health Trust
 P.O. Box 34203
 Seattle, WA 98124-1203
5. For electronic claims submission:

Group F31 WebMD ID 91136

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.