

Please Submit All Medical Claims To:
TEDRO / HL
P. O. Box 419104
St. Louis, MO 63141-9104



IMPORTANT

Please Submit All RX
and Medicare Claims To:
Iron Workers St. Louis District
Council Welfare Plan
2160 S. Foster, Wheeling, IL 60090

MEDICAL CLAIM STATEMENT EMPLOYEE'S STATEMENT



1. Employee's Name _____		Social Security No. _____	Date of Birth _____
Home Address _____		Local Union # _____	
(STREET)			
Telephone # _____		(CITY) _____	(STATE) _____ (ZIP) _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed			
Employer's Name _____			
Address _____			
(STREET)		(CITY) _____	(STATE) _____ (ZIP) _____
2. This claim is for <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Unmarried son <input type="checkbox"/> Unmarried daughter			
Other, explain _____			
3. Spouse's Name _____		Date of Birth _____	Spouse's Social Security No. _____
4. Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name and address of employer _____			
5. If dependent child is over age 18, give name and address of school being attended (if any) on a <i>full-time</i> basis.		NAME OF SCHOOL _____	
		ADDRESS _____	
Are you or your dependents entitled to benefits under any other group insurance plan, Blue Cross/Blue Shield Plan, school plan or governmental plan, including Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No		FAMILY MEMBER INSURED UNDER OTHER PLAN _____	
If yes, please provide necessary information.		NAME & ADDRESS OF OTHER INS. CO. OR ORGANIZATION _____	
		GROUP POLICY NUMBER _____	
<input type="checkbox"/> If for a dependent	Name of Dependent _____	Date of Birth _____	
	Dependent's Occupation, if any _____	Is Dependent child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> If for yourself	Did you lose time from work because of this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, give date last worked before becoming totally disabled _____, 20__ <input type="checkbox"/> AM <input type="checkbox"/> PM		
	and date of return ____/____/____ or expected return to work ____/____/____		
6. Claim is for <input type="checkbox"/> an Accident <input type="checkbox"/> a Sickness			
Briefly describe (for example: heart, pregnancy, fall, etc.) _____			
COMPLETE IF CLAIM IS FOR AN ACCIDENT			
Date/Time _____ Where _____ How _____			
7. Did sickness or injury arise out of or in the course of any employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I authorize any physician, hospital, insurer or any other organization or person having any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by such company to this fund or their duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.			
Employee's Signature _____ Date _____			
PATIENT'S SIGNATURE	Such information may be used to the extent deemed necessary to determine the validity or amount payable in regard to this claim (Parent if patient is a minor) _____ Date _____ 20__		

EMPLOYER'S STATEMENT – To Be Completed for Employee Claim Only

LAST DATE EMPLOYEE WORKED _____	EMPLOYER # _____	NAME OF COMPANY _____	
DATE EMPLOYEE RESUMED WORK _____	IS THE CLAIM ONE WHICH MIGHT COME UNDER WORKMEN'S COMPENSATION OR OCCUPATIONAL DISEASE ACTS? <input type="checkbox"/> Yes <input type="checkbox"/> No	ADDRESS OF COMPANY _____	ZIP CODE _____
IS EMPLOYEE STILL EMPLOYED BY YOU _____	SIGNATURE OF AUTHORIZED REPRESENTATIVE _____	TITLE _____	DATE _____
CURRENT STATUS OF EMPLOYEE: LEAVE OF ABSENCE <input type="checkbox"/> LAID-OFF <input type="checkbox"/> TERMINATED <input type="checkbox"/> RETIRED <input type="checkbox"/>			

PART A TO BE COMPLETED BY PATIENT (INSURED)

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH
INSURED'S NAME (IF PATIENT IS A DEPENDENT)	
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN. I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits. If any, otherwise payable to me for his services as described below, but not to exceed the reasonable and customary charge for those services.	SIGNED (INSURED PERSON) DATE
AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.	SIGNED (PATIENT OR PARENT IF MINOR) DATE

PART B ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS																
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES appropriate date Pregnancy commenced DATE												
3. REPORT OF SERVICES or attach itemized bills																
Date of Services	Place of Services	Description of surgical or medical services rendered	Procedure Code	Charges												
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">O – Doctor's Office</td> <td style="width: 33%;">H – Inpatient Hospital</td> <td style="width: 33%;">NH – Nursing Home</td> </tr> <tr> <td>H – Patient's Home</td> <td>OH – Outpatient Hospital</td> <td>OL – Other Locations</td> </tr> </table>			O – Doctor's Office	H – Inpatient Hospital	NH – Nursing Home	H – Patient's Home	OH – Outpatient Hospital	OL – Other Locations	<table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">TOTAL CHARGES</td> <td style="width: 30%;">\$ _____</td> </tr> <tr> <td>AMOUNT PAID</td> <td>\$ _____</td> </tr> <tr> <td>BALANCE DUE</td> <td>\$ _____</td> </tr> </table>		TOTAL CHARGES	\$ _____	AMOUNT PAID	\$ _____	BALANCE DUE	\$ _____
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TOTAL CHARGES	\$ _____															
AMOUNT PAID	\$ _____															
BALANCE DUE	\$ _____															
4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED?			5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION?													
6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES when and describe			7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO													
8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (Unable to work)			9. PATIENT WAS PARTIALLY DISABLED													
FROM _____ THRU _____			FROM _____ THRU _____													
10. IF STILL DISABLED DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK?			11. PATIENT WAS HOUSE CONFINED													
			FROM _____ THRU _____													
12. DOES PATIENT HAVE OTHER HEALTH COVERAGES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES please identify:																
DATE		PHYSICIAN'S NAME (Please Print)		DEGREE												
PHYSICIAN'S SIGNATURE			TELEPHONE													
<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: 1px solid black; height: 20px;"> </td> <td style="width: 40%; text-align: center;">INDIVIDUAL PRACTITIONERS SS#</td> </tr> <tr> <td style="border: 1px solid black; height: 20px;"> </td> <td style="text-align: center;">ALL OTHER EMPLOYER ID #'S</td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: small;">Must be furnished under authority of law</td> </tr> </table>						INDIVIDUAL PRACTITIONERS SS#		ALL OTHER EMPLOYER ID #'S	Must be furnished under authority of law							
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STREET ADDRESS		CITY OR TOWN		STATE OR PROVINCE												
				ZIP CODE												