

# Painters and Allied Trades District Council #82 Health Care Fund

**GROUP  
5WM00320**

## 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 show your Social Security Number and sign member's signature section. Remember to attach itemized bills.

Return completed form to:

**Painter and Allied Trades District Council #82  
Health Care Fund**  
3001 Metro Drive • Suite 500  
Bloomington, MN 55425  
952-854-0795 • Fax 952-851-3521 • 1-800-535-6373

### MEMBER COMPLETES THIS SECTION

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

### COMPLETE IF CLAIM IS FOR DEPENDENT

Name of Dependent:	Relationship to Member:	Date of Birth:	
Is Dependent employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state Name of Employer:			
Is the Patient Covered by Any Other Insurance, Prepaid Health Plan, Medicare, or Other Governmental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Insured's Name	
Group Insurance Company or Plan's Name:		Policy Number:	
Group Insurance Company or Plan's Address:	City	State	Zip Code
Name of Spouse:	Spouse's Date of Birth:	Spouse's Social Security Number:	

### FOR ALL CLAIMS:

Name 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was injury due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the accident happen on your property? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, address where accident occurred:	Was this due to an auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did injury or illness occur in the course of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you filed this claim under Workmen's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you started a lawsuit related in any way to this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you received any settlement, payment, recovery of benefits, including insurance company or policy, related in any way to this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you hired an attorney to represent you regarding this claim? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Painters and Allied Trades District Council #82 Health Care Fund.

Insured Member's Signature Signed	Date
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# 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 doctor may use this form to report his services and charges.

## Disability

To collect disability benefits, your doctor must complete questions, 1, 2, 4, 5, 7, 8 and 9 and sign and date this form.

## Attending Doctor's Statement

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

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

Is condition due to pregnancy? If Ye, approximate date pregnancy commenced

3. Report of services (or attach itemized bill. If previous form submitted to this carrier, you need to 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 edition)			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	
7. Is 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) From _____ Thru _____		9. Date patient should be able to return to work, if still disabled	
10. Does patient have other health coverage? If Yes, please identify <input type="checkbox"/> Yes <input type="checkbox"/> No				Taxpayers identification Number	
Print Doctor's Name		Doctor's Signature		Degree	Date
Street Address				Telephone (      )	
City		Providence		State	Zip Code

## Member 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 Painters and Allied Trades District Council #82 Health Care 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 Signed

Date