

ASBESTOS WORKERS UNION LOCAL NO. 42 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)					Marital Status:		
Mr.					<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
Mrs.	Member of Local Union No. _____				<input type="checkbox"/> Divorced	<input type="checkbox"/> Legally Separated	
Miss _____	Soc. Sec. No. _____				Date of Birth _____		
No.	Street	City	State	Zip	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
		<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed
		<input type="checkbox"/> Other..... (Relationship)	<input type="checkbox"/> Divorced <input type="checkbox"/> 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: _____ _____ _____
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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
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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

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PATIENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	AGE
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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 <input type="checkbox"/> NO <input type="checkbox"/>	16a. IF AN EMERGENCY CHECK HERE. <input type="checkbox"/>			
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 <input type="checkbox"/> NO <input type="checkbox"/> 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 A 1 2 3 4			10. WAS CONDITION RELATED TO A. PATIENTS EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>				
20. A DATE OF SERVICE	B PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY _____) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. DAYS CHARGES	F. OR UNITS	G. T.O.S.	H. LEAVE BLANK
17. DATE PATIENT ABLE TO RETURN TO WORK		26. HAS BILL BEEN PAID? IF YES, PAID RECEIPTS MUST BE FURNISHED YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE		28. AMOUNT PAID 29. BALANCE DUE	
SIGNED _____		30. YOUR SOCIAL SECURITY NO. _____		31. PHYSICIANS OR SUPPLIERS NAME, ADDRESS, ZIP CODE & TELEPHONE NO.			
32. YOUR PATIENTS ACCOUNT NO.		33. YOUR EMPLOYER I.D. NO.		I.D. NO.			