STONE AND MARBLE MASONS
HEALTH & WELFARE FUND, LOCAL 2, D.C., B.A.C.
7130 Columbia Gateway Drive, Suite A, Columbia, Maryland 21046

PHONE
(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)
Mr.
Mrs.
Miss _____ Soc. Sec. No, _____

No. Street City State Zip

Member of Local Union No. _____

Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Legally Separated

Date of Birth _____
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
		☐ Wife ☐ Husband ☐ Child ☐ Other..... (Relationship)	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ 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: _____

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

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

Spaced for Typewriter—Marks for Tabular Appear on this Line

PATIENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	AGE

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 [ ] [ ] NO	16a. IF AN EMERGENCY CHECK HERE. [ ]
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 [ ] [ ] NO 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 [ ] [ ] NO CHARGES B. ACCIDENT AUTO [ ] [ ] OTHER	

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 SIGNED DATE	26. HAS BILL BEEN PAID? IF YES, PAID RECEIPTS MUST BE FURNISHED YES [ ] [ ] NO 30. YOUR SOCIAL SECURITY NO.	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
			31. PHYSICIANS OR SUPPLIERS NAME, ADDRESS, ZIP CODE & TELEPHONE NO.	
32. YOUR PATIENTS ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.			
	I.D. NO.			