Medical / Dental Claim Form P60

APEA – AFT Health and Welfare Trust
PO Box 34840, Seattle WA 98124-1840
Claims Customer Service Call: (800) 331-6158

Instructions:
Please complete this form, attach all itemized bills, send to the appropriate Claims Office, and keep a copy for your records.

Mail self-submitted Medical and Dental Claims to:
APEA – AFT Health and Welfare Trust, PO Box 34840
Seattle, WA 98124-1840

PART I - TYPE(S) OF CLAIM: Check type(s): □ Medical □ Dental

PART II – EMPLOYEE INFORMATION:

Employee Name:_____ Social Security or ID #_____
(First Name) (Last Name) (M I)

Mailing
Address:_____
(Street) (City) (State) (Zip)

Spouse Name:_____Social Security #_____

PART III - PATIENT DATA: Claim is for: □ Self □ Spouse □ Dependent Child

Patient Name:_____ Birth Date: _____/_____/_____
(First Name) (Last Name) (M I)
If claim is for dependent child, indicate relationship: □ Child □ Step Child □ Legal Guardianship □ Other _____

Is your child developmentally disabled or handicapped? □ Yes □ No If yes contact Claims Office for instructions.

PART IV - OTHER INSURANCE INFORMATION:

Does patient have other health insurance coverage? □ Yes □ No If yes: □ Medical □ Dental □ Vision

Date other coverage began?_____ Date coverage will terminate? _____

Subscriber Name: _____ Subscriber SS#:_____

Other Insurance company or plan administrator's name, address, telephone #, policy/plan #:

_____

PART V - CLAIM INFORMATION (complete only applicable information):

Are expenses related to an injury? □ Yes □ No
If yes, indicate date of injury ____/____/____ and type of injury: □ Automobile □ Home/Recreational

□ Employment-Related: Name, address & telephone of employer: _____

□ Other_____

Briefly describe injury:_____
Note: If claim is for an injury, you will be sent an "accident questionnaire". Please return it 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 and Pension Administration Service, Inc. and the plan holder, 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.
It is unlawful to knowingly provide false, incomplete or misleading facts or information to a Group Insurance Plan for the purpose of defrauding or attempting to defraud the plan. Penalties may include imprisonment, fines, denial of insurance, and/or civil damages.
I authorize benefit payment to the health provider for the services and/or supplies described on this claim form. □ Yes □ No

_____ _____/____/____
Employee Signature Date

CLAIM FILING TIPS

WE WANT YOUR CLAIMS TO BE PAID ACCURATELY AND TIMELY. USING THE FOLLOWING TIPS WILL HELP US GIVE YOU BETTER SERVICE.

- Answer all of the appropriate questions and sign the claim form.
- Always send your claim form and an itemized statement of charges which includes:

    1. Employee name
    2. Patient name
    3. Provider name & Provider Tax ID number
    4. Dates of service
    5. Diagnosis (preferably with code number)
    6. Types of service (preferably with code number)
    7. Charges for each type of service

- Never send a "balance due statement" to the Claims Office.
- Complete a separate form for each patient.
- If you have other Group Insurance or Medicare as your primary coverage you must submit the itemized bill AND a copy of the matching Medicare or other insurance payment explanation.

<u>You may return this form to WPAS, Inc. in one of the following ways:</u>

1. Mail to: APEA – AFT Health and Welfare Trust
   PO Box 34840
   Seattle, WA 98124-1840
2. Fax to: (206) 441-9110
   --or--
3. Email scanned document to: claimsubmission@wpas-inc.com

Claims Customer Service Call: (800) 331-6158

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