LOCAL 348
Health & Welfare Fund
9235 4th Avenue
Brooklyn, NY 11209

Mail Completed Claim Form to:
MAGNACARE
825 East Gate Blvd.
Garden City, NY 11530

STATEMENT OF CLAIM TO BE COMPLETED BY MEMBER
FORMA DE RECLAMO PARA SER COMPLETADA POR EL MIEMBRO

Please Print All Answers (Escriba Con Letra De Malde)

Member's Name ..... ID No .....
Su Nombre *No. de ID*

Member's Address .....
Su Dirección *No.(Número)* *Street (Calle)* *City (Ciudad)* *State (Estado)* *Zip Code (Zona)*

Date of Birth ..... Sex ..... Telephone Number .....
Edad *Sexo* *No. de Teléfono*

Member's Employer ..... Date Employed .....
Empleado Por *Día que fue Empleado*

Check One Box / Marque una Casilla — Single ❑ *Soltero* — Married ❑ *Casado* — Widowed ❑ *Viudo* — Divorced ❑ *Divorciado* — Legally Separated ❑ *Separado Legalmente*

IF THIS CLAIM IS FOR A DEPENDENT, FILL IN THIS SECTION
(SI EL RECLAMO ES PARA UN DEPENDIENTE, LLENE ESTA SECCIÓN)

Dependents Name... ..... Age ..... Sex... ..... Relationship... ..... Is Dependent Married?... .....
Nombre de Dependientes *Edad* *Sexo* *Parentesco* *¿Está Casado El Dependiente?*

ANSWER THE FOLLOWING QUESTIONS FULLY, FAILURE TO DO SO MAY DELAY PAYMENT

If this claim is for your dependent:

a. Is your dependent employed? ❑YES ❑ NO
If yes, name of employer..... .....
.....
Address... .....

b. Is this claim the result of an accident? ❑ YES ❑ NO
If yes, give name and address of your lawyer:
Name .....
Address.....

Is the injury or illness for which claim is being made covered under any other insurance policy, or any other group plan?
❑ YES ❑ NO

a. If yes, give name of plan .....

Is this the first medical, surgical, hospital or disability claim you have filed? ❑ YES ❑ NO

NOTE: You must attach a PAID BILL if you are claiming reimbursement. If you wish the PLAN to pay the doctor you must sign item 8 on the "Doctor's Statement" of the claim form.

CONTESTE COMPLETAMENTE LAS SIGUIENTES PREGUNTAS, SI NO LO HACE, PUEDE DEMORAR EL PAGO.

Si este reclamo es para su dependiente:

a. ¿Está empleado su dependiente? ❑ SI ❑ NO
Si está empleado, nombre del empleador.....
.....
Dirección .....

b. ¿Es éste reclamo el resultado de un accidente? ❑ SI ❑ NO
En caso afirmativo, dé el nombre y dirreción de su abogado:
Nombre .....
Dirección .....

¿Esta herida o enfermedad por la cual se hace reclamo, está cubierta bajo alguna otra póliza de seguro, o algún otro plan de grupo?
❑ SI ❑ NO En caso afirmativo,

Dé el nombre del plan .....

¿Es éste su primer reclamo médico, quirúrgico, hospitalario o de incapacidad?
❑ SI ❑ NO

NOTA: Usted debe incluir una FACTURA PAGADA si está reclamando reembolso. Si desea que el Plan de Beneficios pague el médico debe firmar el renglón 8 de la "Declaración del Médico" de la forma de reclamo.

I have read the instructions on the page above. The foregoing statements including any accompanying statements are to the best of my knowledge true and complete. I authorize the release to the Fund any medical and/or insurance information required to process this claim. A Photostat of this authorization may be honored.

He leído las intrucciones descritas arriba. Las declaraciones anteriores, incluyendo cualquier otra declaración adicional adjunta, son verdaderas y completas según mi leal saber y entender. Autorizo a entregar al Fondo de cualquier información médica y/o de seguro necesaria para procesar mi reclamo. Puede aceptarse una fotostática de esta autorización.

Member's Signature ..... Date .....
Firma del Miembro/a *Fecha*

Do not mail this claim unless your doctor has completed and signed the "Doctor's Statement."

Member: Be sure to sign your name above.
Miembro: Esté seguro de firmar su nombre arriba.

No mande por correo este reclamo a menos que su médico haya completado y firmado la "Declaración del Médico."

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HOSP OR DOCTOR ID

CLAIM NO.

MEDICAL BENEFITS CLAIM FORM

PATIENT INFORMATION

1. PATIENT'S NAME (first name, middle initial, last name)

2. PATIENT'S DATE OF BIRTH

3. WAS CONDITION RELATED TO
PATIENT'S EMPLOYMENT? ❑ YES ❑ NO
AN AUTO INSURANCE ACCIDENT? ❑ YES ❑ NO

4. PATIENT'S ADDRESS (Street, city, state, ZIP code)

5. PATIENT'S SEX
❑ MALE ❑ FEMALE

6. PATIENT'S RELATIONSHIP TO MEMBER
SELF❑ SPOUSE❑ CHILD❑ OTHER❑

7. OTHER HEALTH COVERAGE- Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

8. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNED: Employee or Authorized Person

PHYSICIAN OR SUPPLIER INFORMATION

9. DATE OF:

10. ILLNESS (FIRST SYMPTOM OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

11. DATE FIRST CONSULTED YOU FOR THIS CONDITION

12. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS
YES ❑ NO ❑

13. DATE PATIENT ABLE TO RETURN TO WORK

14. DATES OF TOTAL DISABILITY
FROM | THROUGH

15. DATES OF PARTIAL DISABILITY
FROM | THROUGH

16. NAME OF REFERRING PHYSICIAN

17. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES.
ADMITTED | DISCHARGED

18. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)

19. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES ❑ NO ❑

20. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.
4.

A. DATE OF SERVICE	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F

21. DOCTOR/FACILITY:
ARE YOU AFFILIATED WITH THE MAGNACARE PPO NETWORK? YES ❑ NO ❑

22. TOTAL CHARGE

23. AMOUNT PAID

24. BALANCE DUE

25. SIGNATURE OF PHYSICIAN OR SUPPLIER
SIGNED DATE

26. LICENSE NUMBER

27. YOUR ID #

28. YOUR PATIENT'S ACCOUNT NO.

29. YOUR EMPLOYER I.D. NO.

30. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NUMBER
I.D. NO.

PLACE OF SERVICE CODES
1- (IH) – INPATIENT HOSPITAL
2- (OH) - OUTPATIENT HOSPITAL
3- (O)- DOCTOR'S OFFICE
4- (H)- PATIENTS HOME
5- (NH)- NURSING HOME
6- (OL)- OTHER LOCATIONS

ICDA- INTERNATIONAL CLASSIFICATION OF DISEASES

CPT-CURRENT PROCEDURAL TERMINOLOGY (CURRENT EDITION)

This form is confidential / Esta tarjeta es confidencial