

WASHINGTON-IDAHO OPERATING ENGINEERS HEALTH & SECURITY FUND

EMPLOYEE STATEMENT						
<input type="checkbox"/> Check here if your address is new.						
PART 1 – EMPLOYEE INFORMATION						
EMPLOYEE NAME – First		Initial	Last	<input type="checkbox"/> M <input type="checkbox"/> F	EMPLOYEE WPAS ID # OR SOCIAL SECURITY NO.	EMPLOYEE BIRTHDATE Mo. Day Year
HOME ADDRESS STREET		CITY		STATE	ZIP	PHONE
EMPLOYED BY						LOCAL NO.
PATIENT'S NAME – First		Initial	Last	<input type="checkbox"/> M <input type="checkbox"/> F	PATIENT ID # OR SOCIAL SECURITY NO.	PATIENT BIRTHDATE Mo. Day Year
RELATION TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child						
EMPLOYEE MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGAL SEP. <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVOCED		IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> ADOPTED CHILD <input type="checkbox"/> FOSTER CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> GUARDIANSHIP <input type="checkbox"/> OTHER (EXPLAIN) _____			IS DEPENDENT CHILD IS AGE 26 OR OLDER? IF "YES", DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF SPOUSE (if not patient listed above)				SPOUSE BIRTHDATE Mo. Day Year	SPOUSE ID # OR SOCIAL SECURITY NO.	
IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME & ADDRESS SPOUSE'S EMPLOYER				
PART 2 – INSURANCE INFORMATION						
ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO						
IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER NAME _____ ADDRESS _____						
NAME OF SUBSCRIBER _____ SUBSCRIBER ID # OR SOCIAL SECURITY NO. _____						
OTHER GROUP PLAN COVERS: <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN OTHER GROUP PLAN POLICY OR I.D. NO. _____						
OTHER GROUP PLAN INCLUDES: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION						
ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES { NAME OF PERSON COVERED _____ MEDICARE EFFECTIVE DATE _____						
PART 3 – ACCIDENT/INJURY INFORMATION						
WAS CARE REQUIRED BECAUSE OF AN INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DID ACCIDENT OCCUR WHILE AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO						
DATE INJURED _____ DESCRIBE HOW INJURY OCCURRED: _____						
HAS CLAIM BEEN FILED WITH LABOR AND INDUSTRIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", GIVE CLAIM NUMBER _____						
FOR TIME LOSS: LAST DAY WORKED _____ DATE RETURNED TO WORK _____						
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his or her services but not to exceed the reasonable and customary charge for those services. Do not sign if bills have been paid.				I hereby certify that the foregoing statements, including any accompanying statements, are true and correct and complete to the best of my knowledge, and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge. A photocopy of this authorization is as valid as the original.		
Employee Signature _____ Date _____				Patient Signature (if not minor child) _____		
Employee Signature _____ Date _____				Employee Signature _____ Date _____		
PROCEDURE FOR FILING A CLAIM						
1. Complete all applicable sections of the "Employee Statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim. 2. Attach an itemized bill for all charges relating to this claim. If claim is for disability, a doctor MUST complete the "Attending Physician's Statement" on the reverse side of this form. 3. Complete a separate form for each patient. 4. Mail completed form and itemized bill to:						
WA-ID OPERATING ENGINEERS P.O. BOX 34567 SEATTLE, WASHINGTON 98124-1567 PHONE: (800) 351-6480						
To insure prompt payment submit only itemized bills. An itemized bill is the actual bill from the provider showing: a) date of service; b) diagnosis; c) procedure done and d) cost of each procedure. A "balance due" or non-itemized bill is NOT acceptable.						
If you have other Group Insurance or Medicare as your primary coverage you need to submit the itemized bill AND a copy of the matching insurance or Medicare payment explanation.						

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME			AGE	
DIAGNOSIS AND CONCURRENT CONDITIONS				
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", APPROXIMATE DATE PREGNANCY COMMENCED:				
COMPLETE REPORT OF SERVICES OR ATTACH AN ITEMIZED BILL. IF A PREVIOUS FORM HAS BEEN SUBMITTED, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT.				
DATES OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	C.P.T. PROCEDURE CODES	CHARGES	
TOTAL CHARGES			\$	
AMOUNT PAID			\$	
BALANCE DUE			\$	
THIS AREA MUST BE COMPLETED BY THE ATTENDING PHYSICIAN IF APPLYING FOR TIME LOSS/DISABILITY BENEFITS.				
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:		DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:		
PATIENT EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", WHEN AND DESCRIBE:		PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) GIVE DATES: FROM _____ THRU _____		LAST DAY WORKED:		
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:		DATE EMPLOYEE RETURNED TO WORK:		
DOES PATIENT HAVE OTHER HEALTH COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", PLEASE IDENTIFY				
DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
STREET ADDRESS		CITY	STATE	ZIP
				PHONE
INDIVIDUAL PRACTITIONERS TIN OR SS NO.		NPI		