WASHINGTON-IDAHO OPERATING ENGINEERS HEALTH & SECURITY FUND

EMPLOYEE STATEMENT

☐ **Check here if your address is new.**

PART 1 – EMPLOYEE INFORMATION

EMPLOYEE NAME – First / Initial / Last	☐ M ☐ 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	☐ M ☐ F	PATIENT ID # OR SOCIAL SECURITY NO.	PATIENT BIRTHDATE Mo. Day Year	RELATION TO EMPLOYEE ☐ Self ☐ Spouse ☐ Child

EMPLOYEE MARTIAL STATUS

☐ MARRIED ☐ LEGAL SEP.
☐ SINGLE
☐ WIDOWED
☐ DIVOCED

IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU

☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ FOSTER CHILD
☐ STEP CHILD ☐ GUARDIANSHIP

☐ OTHER (EXPLAIN) _____

IS DEPENDENT CHILD IS AGE 26 OR OLDER?

IF "YES", DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? ☐ YES ☐ NO

NAME OF SPOUSE (if not patient listed above)	SPOUSE BIRTHDATE Mo. Day Year	SPOUSE ID # OR SOCIAL SECURITY NO.

IS SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME & ADDRESS SPOUSE'S EMPLOYER

PART 2 – INSURANCE INFORMATION

ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? ☐ YES ☐ 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: ☐ PATIENT ☐ SPOUSE ☐ CHILDREN OTHER GROUP PLAN POLICY OR I.D. NO. _____

OTHER GROUP PLAN INCLUDES: ☐ MEDICAL ☐ DENTAL ☐ VISION

ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? ☐ YES ☐ NO IF YES

NAME OF PERSON COVERED _____

MEDICARE EFFECTIVE DATE _____

PART 3 – ACCIDENT/INJURY INFORMATION

WAS CARE REQUIRED BECAUSE OF AN INJURY? ☐ YES ☐ NO DID ACCIDENT OCCUR WHILE AT WORK? ☐ YES ☐ NO

DATE INJURED _____ DESCRIBE HOW INJURY OCCURRED: _____

HAS CLAIM BEEN FILED WITH LABOR AND INDUSTRIES? ☐ YES ☐ 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.

Employee Signature _____ Date _____

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.

Patient Signature (if not minor child) _____

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? ☐ YES ☐ NO

PREGNANCY? ☐ YES ☐ 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 COMPLTED 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? ☐ YES ☐ NO IF "YES", WHEN AND DESCRIBE:	PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ 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? ☐ YES ☐ 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