



Health and Welfare Fund
 6281 Youngstown-Warren Rd., Suite 240
 Niles, Ohio 44446-4690
 330-652-3475
 Toll Free 800-362-9354

EMPLOYEE'S STATEMENT OF CLAIM

This side of the form is for information about the employee and the patient and the reason for the claim. Please read and complete the form carefully. The provider should complete and sign the other side of this form. Please use one form for each patient and each provider. Your signature is required in question number (10) if you want us to send payment directly to the provider. Claims should be filed within 90 days.

WHO IS THE COVERED CARPENTER?

NAME		Social Security No.	Date of Birth
STREET		Local Union	New Address <input type="checkbox"/> Yes <input type="checkbox"/> No
CITY	STATE	ZIP	Telephone No.
Spouse Name / S. S. Number		Spouse Date of Birth	Is Spouse Employed <input type="checkbox"/> Yes <input type="checkbox"/> No
Name & Address Spouse Employer			

IF THIS CLAIM IS FOR YOU, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Date Last Worked	Date Disabled	Date Able to Return to Work	Date Returned To Work	Are you receiving Unemployment Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Most Recent Employer	Are you applying for accident and sickness benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No
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IF THIS CLAIM IS FOR A DEPENDENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Dependent's Name	S.S. Number	Relationship	Date of Birth	Sex	Married <input type="checkbox"/>	Single <input type="checkbox"/>
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IF THE DEPENDENT IS A SON OR DAUGHTER AGE 19 OR OLDER, COMPLETE THE FOLLOWING:

Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If a Student, Provide Name and Address of School	VERIFICATION REQUIRED EACH GRADING PERIOD
Is the Son / Daughter Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Disability Occur Before Age 19 <input type="checkbox"/> Yes <input type="checkbox"/> No	

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

<p>1. Is this claim because of an accident <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is someone else responsible for causing the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is a claim being made against the other person or their insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Was the patient injured at work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is this a Worker's Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Is this claim because of an illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, briefly describe the illness _____ _____</p> <p>5. Is this claim due to an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please explain how, when & where injury occurred. _____ _____</p> <p>6. Is the patient covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Effective Date of Part A _____ Part B _____</p>	<p style="text-align: center;">PLEASE NOTE-FUND REGULATIONS REQUIRE MEDICAL EVIDENCE OF DISABILITY TO BE FILED</p> <p>7. Do you or any other family member have <input type="checkbox"/> Yes <input type="checkbox"/> No other group insurance? If yes, what is the Group Name _____ Address _____ _____ Policy Number _____ Insured's Social Security No. _____ Policy Holder's Name _____</p> <p>8. Who provided the services for this claim? _____</p> <p>9. When was the patient first treated for this illness or injury? _____</p> <p>10. Who do you want us to pay? ...Pay me <input type="checkbox"/> Pay the provider <input type="checkbox"/></p> <p>_____ Your signature (required to pay provider)</p>
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Any person who knowingly and with intent to defraud or deceive the Ohio Carpenters Health and Welfare Fund and files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.
 I hereby certify that the information contained herein is true and correct. I further certify that I am not filing for and receiving unemployment compensation benefits or Worker's Compensation benefits for the same period of time for which I am filing for accident and sickness benefits with the Ohio Carpenters Health and Welfare Fund.
 To all physicians and other health professionals, and all hospitals and other health care institutions:
 You are authorized to provide Ohio Carpenters Health and Welfare Fund any information concerning health care, advice, treatments or supplies provided the Patient (including that relating to mental illness).
 This information will be used for the purpose of evaluating and administering claims for benefits.
 This authorization is valid for the eligibility period under which a claim has been submitted.
 I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.



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CERTIFICATE OF ATTENDANCE PHYSICIAN

PATIENT'S NAME _____ AGE _____

ADDRESS _____

HISTORY:
 Type of Disability? Occupational Accident Illness
 Symptoms appeared, or accident occurred (Month) (Day) (Year)
 Subject symptoms
 Objective findings
 (Results of tests, X-rays, EKG's, examination)

PATIENT'S CONDITION:
 Patient is Ambulatory Bed Confined House Confined Hospital Confined
 Diagnosis
 (Include ICDA Code)
 If disabled, date disability began
 Patient is Recovered Improved Unimproved Retrogressed
 If disabled, when may patient be able to return to work? Unknown Never Approximate Date _____

CARDIAC:
 Functional Capacity Class 1 (No limitation) Class 2 (Slight limitation) Class 3 (Marked limitation) Class 4 (Complete limitation)

TREATMENT:

Dates of office visits									
Procedure Code									
Charge per visit									
Dates of hospital services									
Charge									

Surgical procedure/Date/Charge
 If a minor surgical procedure, could it have been performed on an outpatient basis? Yes No
 If No, please explain the reason for the hospital confinement, including all diagnosis.

Laboratory/X-ray services/Date/Charge

Medication, therapy, appliances, etc., prescribed

Physician's Signature _____ Name _____ (please print)

Address _____

Date _____ Tax Payer I.D. Number _____ Telephone (_____) _____