

**PLUMBERS & PIPEFITTERS LOCAL NO. 520  
HEALTH AND WELFARE FUND  
MEDICAL CLAIM FORM**

*RETURN TO:*

D. H. EVANS ASSOCIATES, INC.

P.O. BOX 6480 • HARRISBURG, PA 17112-0480 • (717)671-8551 • FAX: (717)671-8602

**PATIENT & INSURED INFORMATION**

1. PATIENT'S NAME <i>(First name, middle initial, last name)</i>	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME <i>(First name, middle initial, last name)</i>
4. PATIENT'S ADDRESS <i>(Street, City, State, Zip Code)</i>	5. PATIENT'S SEX ___ MALE ___ FEMALE	6. INSURED'S ID No. or <b>Social Security No.</b> <i>(include any letters)</i>
	7. PATIENT'S RELATIONSHIP TO INSURED ___ SELF ___ SPOUSE ___ CHILD ___ OTHER	8. DESCRIBE SICKNESS OR ACCIDENT DETAILS
9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO: A. Patient's Employment ___ Yes ___ No B. An Auto Accident ___ Yes ___ No C. Other Accident ___ Yes ___ No	

**11. INSURED'S AND PATIENT'S SIGNATURES**

The undersigned assigns to the Plan any amount received from any party, in any action at law, compromise, settlement, or agreement to the extent of the Plan's benefits paid for the undersigned which are for reimbursable causes in accordance with the rules of the Plan.  
I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Plan, of any facts concerning the injury, illness or treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original. This release is valid until revoked by me in writing.

**SIGNED (INSURED) \_\_\_\_\_ DATE \_\_\_\_\_ SIGNED (Patient) \_\_\_\_\_ DATE \_\_\_\_\_**

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

**SIGNED (INSURED OR AUTHORIZED PERSON)**

**PHYSICIAN OR SUPPLIER INFORMATION**

13. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	14. DATE FIRST CONSULTED YOU FOR THIS CONDITION?	15. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES _____ NO _____
16. DATE PATIENT ABLE TO RETURN TO WORK	17. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	18. DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____
19. NAME OF REFERRING PHYSICIAN		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED <i>(if other than home or office)</i>		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES _____ NO _____ CHARGES: _____

**23. DIAGNOSIS OR 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(S) OF SERVICE	B PLACE OF SERVICE	C TYPE OF SERVICE	D PROCEDURES, SERVICES OR SUPPLIES	E DIAGNOSIS	F CHARGES	G DAYS OR UNITS	(EXPLAIN UNUSUAL SERVICES CIRCUMSTANCES)

25. SIGNATURE OF PHYSICIAN OR SUPPLIER  SIGNED _____ DATE _____	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES _____ NO _____	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
	30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.			