Medical / Dental Claim Form

ALASKA HOTEL, RESTAURANT AND CAMP EMPLOYEES, HEALTH AND WELFARE TRUST

A Self-Funded Health Plan

P.O. Box 34564, Seattle, WA 98124-1564

Instructions:
Complete this form, attach all itemized bills, send to the plan administrator at the address above, & keep a copy for your records.

For Toll-Free Assistance Nationwide Call:
Welfare & Pension Administration Service
Claims Office 1-800-331-6158

PART I - TYPE(S) OF CLAIM: Check type(s): Medical Dental **Note: Retirees and dependents are not eligible for dental benefits.**

PART II - EMPLOYEE DATA:

Employee Name:______________________________ Social Security No.:____________________
(First Name) *(Last Name)*

Mailing Address:____
(Street) *(City)* *(State)* *(Zip)*

PART III - PATIENT DATA: Claim is for: Employee Spouse Dependent Child

Patient Name:______________________________ Birth Date: ____/____/____
(First Name) *(Last Name)*

If child is age 19 or older, is child a full-time student? Yes No

If yes, current semester enrollment form must be on file

If no, does child have a developmental disability, physical handicap?

Yes No

If claim is for dependent child, indicate relationship:

Child Step Child Legal Guardianship

Other____________________

PART IV - OTHER INSURANCE INFORMATION:

Does patient have other health insurance coverage: Yes No If yes, please complete the following for each policy/plan:
Insurance company/plan administrator's name, address, telephone #, policy/plan #, and types of coverage:

1.____ Medical Dental

2.____ Medical Dental

Is spouse employed? Yes No If yes, please write name, address and telephone number of employer and/or union local:

____

PART V - CLAIM INFORMATION (complete only applicable information):

Are expenses related to an accident? Yes No If yes, indicate date of accident ____/____/____ and type of accident:

Automobile

Employment-Related: Name, address & telephone of employer:____________________

Home/Recreational Other____________________

Briefly describe accident:____

____

Note: If claim is related to an accident, you will receive an "accident questionnaire". Respond promptly to expedite claim processing.

PART VI - AUTHORIZATION TO PROCESS CLAIM:

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Welfare & Pension Administration Service, Inc. (WPAS) and the plan holder, or their representatives, any information regarding my and/or my dependent's health history, symptoms, treatment, examination results or diagnosis. This authorization shall be considered valid for the duration of the claim. ***Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.***

I AUTHORIZE BENEFIT PAYMENT TO THE HEALTH PROVIDER FOR THE SERVICES AND/OR SUPPLIES DESCRIBED ON THIS CLAIM FORM. Yes No

______________________________________ ____/____/____
Eligible Participant's Signature Date

ATTENDING PHYSICIAN'S/DENTIST'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

DATE OF SERVICES	DESCRIPTION OF SERVICES RENDERED	PROCEDURES CODE	CHARGES
		TOTAL CHARGES	$
		AMOUNT PAID	$
		BALANCE DUE	$

THIS AREA MUST BE COMPLETED BY THE ATTENDING PHYSICIAN/DENTIST

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST CONSULTED 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
DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES NO IF "YES", PLEASE IDENTIFY	

DATE	PHYSICIAN'S /DENTIST'S Name (PRINT)	SIGNATURE	DEGREE	TELEPHONE
STREET ADDRESS	CITY – STATE – ZIP CODE		INDIVIDUAL PRACTITIONERS TIN OR SS#	

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 related to this claim.
3. Complete a separate form for each patient.
4. **MAIL COMPLETED FORM AND ITEMIZED BILLS TO:**

ALASKA HERE HEALTH & WELFARE TRUST
P.O. BOX 34564
SEATTLE, WASHINGTON 98124-1564
PHONE (206) 441-7574 OR (800) 331-6158

To ensure 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 Medicare or other insurance payment explanation.