

**JOINT WELFARE FUND — Local 16
MEDICAL CLAIM FORM**

FABIAN & BYRN LLC
204 EAGLE ROCK AVE., 2ND FL
ROSELAND, NJ 07068
973 228-4200 FAX 973 228-4240

All Information Is Provided.

INFORMATION WE NEED FROM YOU	
1. EMPLOYEE'S NAME (First, Middle Initial, Last)	2. PATIENT'S NAME (if different from employee)
4. EMPLOYEE'S ADDRESS AND PHONE NOS. Street _____ City _____ State _____ Zip _____ Home Phone No. () _____ Work Phone No. () _____	5. PATIENT'S DATE OF BIRTH MO. DAY YR. 6. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> 7. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> B. An ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> C. An EMERGENCY? YES <input type="checkbox"/> NO <input type="checkbox"/> If an EMERGENCY and/or ACCIDENT: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Date _____, 20____ time _____ Description (nature of EMERGENCY and/or ACCIDENT how and where accident happened) _____
8. EMPLOYEE'S SOCIAL SECURITY NUMBER [][][] - [][][] - [][][][][]	3. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> If Child Unmarried and primarily dependent on employee for support <input type="checkbox"/> YES <input type="checkbox"/> NO FULL TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE _____

9. IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO SPOUSE'S DATE OF BIRTH _____ If Yes, Name of Spouse _____ Spouse's Social Security No. [][][] - [][][] - [][][][][] Name, Address & Phone Number of Spouse's Employer Name _____ Street _____ City _____ State _____ Zip _____ Phone No. () _____	10. DO YOU OR YOUR DEPENDENTS HAVE ANY OTHER GROUP HEALTH COVERAGE (including Medicare) <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes Name and Address of Other Health coverage _____ Contract or Identification No. of Other Health Coverage _____
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11. Check one:
 I authorize payment of medical benefits directly to the below named Doctor, Provider or Supplier. Authorizations will be honored only if a valid Tax Identification or Social Security Number for the provider is shown on the claim form.
or
 Benefits should be paid directly to me.
Employee's Signature _____ Date _____

12. I hereby authorize any Insurance Company, organization, employer, hospital, physician, surgeon or pharmacist to release any information requested with respect to this claim and the attached bills. I certify that the information furnished by me in support of this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. Further, I agree that, if any benefit payments are paid by the Welfare Fund for myself or my eligible dependents, and I or my dependents recover money from any person or organization accepting responsibility for these costs, I will repay the Welfare Plan for the amount of the benefit payments. My failure to cooperate with the Welfare Fund by not repaying the Plan will be reason for the Welfare Plan to withhold further Welfare Fund benefits until such monies are recouped.
Employee's Signature _____ Retired Yes No
Also Dependent (if patient, and not a minor) _____ Date _____

INFORMATION TO BE COMPLETED BY YOUR DOCTOR OR PROVIDER (Include Itemized Bill)

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 <input type="checkbox"/> NO <input type="checkbox"/>
16. DATE PATIENT ABLE TO RETURN TO WORK	17. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____
18. NAME OF REFERRING PHYSICIAN		19. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____
20. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)		21. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> AMOUNT OF CHARGES \$ _____

22. 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 _____

23. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE** (Explain unusual services or circumstances)	D† TYPE OF SERVICE	E CHARGES	F DAYS OR UNITS	G†† DIAGNOSIS CODE

24. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____	25. ENTER THE TAXPAYER IDENTIFICATION NUMBER TO BE USED FOR FORM 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFICATION NUMBER.	26. TOTAL CHARGE	27. AMOUNT PAID	28. BALANCE DUE
30. YOUR PATIENT'S ACCOUNT NO.	29. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.			

*PLACE OF SERVICE CODES
1 - (IH) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home
5 - Day Care Facility (PSY)
6 - Night Care Facility (PSY)
7 - (NH) - Nursing Home
8 - (SNF) - Skilled Nursing Facility
9 - Ambulance
0 - (OL) - Other Locations
A - (IL) - Independent Laboratory
B - Other Medical Surgical Facility
C - (RTC) - Residential Treatment Center
D - (STF) - Specialized Treatment Facility
†TYPE OF SERVICE CODES
1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
M - Alternate Payment for Maintenance Dialysis
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery
**PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR ALL SERVICES ††Please use ICD-9-CM For Diagnosis