

# SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND

501 Shatto Place, 5<sup>th</sup> Floor • Los Angeles, CA 90020 • (800) 595-7473 • (213) 385-6161 • Fax: (213) 383-0725 • [www.scptac.org](http://www.scptac.org)

## CLAIM FORM

- (i) This Claim form is necessary to determine eligible benefits. All questions must be answered or claim form will be returned. This will delay claim processing.
- (ii) Submit a *new claim* form for *each* new accident or illness. In the event of an on going/chronic condition, a new claim form is required once every 6 months.

### IMPORTANT : Please attach all related medical bills

**PART I, II, III & IV:** Must be completed.

Medical Bills will not be honored unless *signed* in PART IV.

**PART V:** Must complete if benefits are to be made payable to the provider of service.

Benefit payments will be made directly to the Affiliated Health Fund participating hospitals and physicians unless you provide the Trust Fund with proof of your payment to the provider.

**CLAIM FORMS**  
can also be  
obtained at  
[www.scptac.org](http://www.scptac.org)  
**Rev 01/04**

### PART I: Member Information

NAME SSN Local Union#

STREET CITY STATE ZIP

ARE YOU WORKING?  NO  YES If YES, EMPLOYER: \_\_\_\_\_

### PART II: Patient Information

Patient's name, SSN, date of birth and address (if different from above):

NAME SSN Date of Birth

STREET CITY STATE ZIP

RELATIONSHIP:  SPOUSE Spouse's employer name and address:  
\_\_\_\_\_  
\_\_\_\_\_

DEPENDENT Dependant's relationship: \_\_\_\_\_  
Is Dependent a full time student?  YES  NO  
If YES, NAME OF SCHOOL: \_\_\_\_\_

PATIENT:  Male  Female  
GENDER

PATIENT MARITAL:  Single  Married  
STATUS  Divorced

### PART III: Claim Information

A) Are YOU or PATIENT insured under any other GROUP HOSPITAL OR MEDICAL INSURANCE or PLAN?

NO  YES If YES: **Name of Covered Individual:** \_\_\_\_\_

**Policy No.:** \_\_\_\_\_

Effective Date: **FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

Name and Address of Insurance Company or Plan:

\_\_\_\_\_  
\_\_\_\_\_

B) Is this patient's condition job related?

NO  YES If YES, has patient or does patient intend to file a claim for Worker's Compensation?

NO  YES

C) Is patient's condition due to any kind of accident or mishap? (Example: slip & fall, car collision, etc.)

NO  YES If YES, **WHEN?** Date & Time: \_\_\_\_\_

**WHERE?** \_\_\_\_\_

**HOW?** \_\_\_\_\_

Was there another party involved in the accident?  
(Example: Other driver, neighbor, retail store, etc.)

NO  YES

If YES, name and address of other party:

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

Name and address of other party Insurance Company or Plan:

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

### PART IV: Authorization

I/We hereby certify that the foregoing statements including any accompanying statements are true, correct and complete to the best of my/our knowledge. I/We hereby authorize the attending physician or any hospital to furnish and disclose to the Southern California Pipe Trades Health & Welfare Fund or its agent all records and information concerning my physical condition that are within their possession or knowledge. I/We further authorize the Health & Welfare Fund to use or disclose the information contained in its claim files in whatever deemed necessary for the purpose of determining the reasonableness of any of the expenses submitted herewith or the propriety of this claim. I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Southern California Pipe Trades Health & Welfare Fund with information regarding benefits to which I/we may be entitled.

X \_\_\_\_\_  
**Member's Signature**

\_\_\_\_\_  
**Member's SSN**

\_\_\_\_\_  
**Date**

*If claim is for spouse, spouse must also sign*

X \_\_\_\_\_  
**Spouse's Signature**

\_\_\_\_\_  
**Spouse's SSN**

\_\_\_\_\_  
**Date**

### PART V: Payment Authorization (Payment authorization for non-AHF providers)

If you wish benefits to be paid to your doctor, execute the following authorization. Otherwise the benefits will be paid solely to you. The undersigned hereby authorizes payment of whatever benefits may be due the undersigned (except Weekly Disability) by check paid to the order of the physician or surgeon to the extent of the physician's or surgeon's charges itemized on statement attached.

X \_\_\_\_\_  
**Member's Signature**

\_\_\_\_\_  
**Date**