STATEMENT OF CLAIM

GEMGroup

COMPLETED FORM TO BE RETURNED TO:

N.E.C.A. LOCAL UNION NO. 313, IBEW
3 GATEWAY CENTER
401 LIBERTY AVE., STE 1200
PITTSBURGH, PA 15222-1024

TELEPHONE NUMBERS:
412-471-2885
1-800-242-8923

INSTRUCTIONS: This form is to be used to submit a claim for services covered under your plan. To avoid having your claim returned, please be sure all information is correct and complete. **IMPORTANT-** If a member is unable to work due to a non-occupational illness or injury, a special form must be submitted to claim weekly accident and sickness benefits.

PLEASE PRINT OR TYPE

THIS SIDE OF FORM IS TO BE COMPLETED BY MEMBER

1. Member's Name ______________________ *Last* *First* *Initial* Social Security No. ______________ Home Telephone No. ______________

2. Home Address ______________________ *Street Number and Name* *City* *State and Zip Code*

3. Name of Member's Employer ______________________ Local Union No. ______________

4. Patient's Name ______________________ Patient's Sex ☐ Male ☐ Female Birth Date ___/___/___ *Month* *Day* *Year* ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Legal Separation

   Relationship to Member ☐ Self ☐ Spouse ☐ Child If child is age 19 or older: Is he/she a full time student? __________ School ______________

5. Symptoms of Illness or Injury requiring treatment ______________________

6. Was the treatment required as a result of an accidental injury? ☐ Yes ☐ No If Yes, complete the following:

   Date of injury ______________ Place of injury ______________________

   How injury occurred ______________________

7. Is patient covered under other Insurance offering benefits for Hospitalization, Surgical, Medical or Dental Expenses? ☐ Yes ☐ No If Yes, complete the following:

   Name of Insured ______________ Name of Insurance Co. ______________
   Date of Birth ______________
   Address of Insurance Co. ______________ Policy, Contract, or Identification Numbers ______________

8. Is patient covered under Medicare? ☐ Yes ☐ No If Yes, attach form from Medicare carrier which explains the benefits paid by Medicare and an itemized bill.

9. Was illness or injury caused by employment? ☐ Yes ☐ No If Yes, do not submit claim to Medical Fund. Submit to Worker's Compensation Insurance Company.

10. Do you wish payment to be made directly to the Physician? ☐ Yes ☐ No

11. I certify that the above information is correct and that I have coverage with the Medical Fund. I apply for benefits under this coverage and authorize any physician, nurse, hospital, or other providers or suppliers in possession of information concerning the patient to furnish such information to the Medical Fund upon request.

    Date ______________ Signature of Member ______________________

HAVE YOU
COMPLETED FORM IN FULL
ATTACHED NECESSARY MEDICARE EXPLANATION OF BENEFITS STATEMENTS
ATTACHED NECESSARY STATEMENT ON OTHER INSURANCE PAYMENTS

NOTE: NEED NOT BE COMPLETED IF AN ITEMIZED BILL, INCLUDING PHYSICIAN TAX ID, IS ATTACHED.

PART 3 — ATTENDING PHYSICIAN OR SUPPLIER'S STATEMENT

1. PATIENT'S NAME (First name, middle initial, last name)

RELATIONSHIP TO EMPLOYEE

BIRTHDATE: Month | Day | Year

2. PATIENT'S ADDRESS

3. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

4. DATE FIRST CONSULTED YOU FOR THIS CONDITION

5. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐

6. DATE PATIENT ABLE TO RETURN TO WORK

7. DATES OF TOTAL DISABILITY FROM THROUGH

8. NAME OF REFERRING PHYSICIAN

9. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☐

10. DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY

PREGNANCY? YES ☐ NO ☐ IF YES, APPROXIMATE DATE PREGNANCY COMMENCED. DATE

11. 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

12. A DATE OF SERVICE	B* Place of Service	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN OR ATTACH ITEMIZED STATEMENT — PROCEDURE CODE (IDENTIFY:)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F FOR OFFICE USE ONLY

16. *PLACE OF SERVICE CODES
- 1 — (IH) — INPATIENT HOSPITAL
- 2 — (OH) — OUTPATIENT HOSPITAL
- 3 — (O) — DOCTOR'S OFFICE
- 4 — (H) — PATIENT'S HOME
- 5 — (NH) — NURSING HOME

PHYSICIAN'S EMPLOYER I.D. NO.

CLAIM CANNOT BE PROCESSED IF OMITTED

13. TOTAL CHARGE

14. AMOUNT PAID

15. BALANCE DUE

18. SIGNATURE OF PHYSICIAN OR SUPPLIER

SIGNED DATE

19. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.