HEALTH AND BENEFIT TRUST FUND OF THE ENGINEERS UNION LOCAL 94-94A

337 West 44th Street, New York, NY 10036 - Tel. (212) 541-9880

COMMERCIAL DIVISION MEDICAL CLAIM FORM

(Home Health Care, Durable Medical Equipment, Physical Therapy and Chemotherapy Require Pre-Authorization.Call (212) 307-1585 for more information.)

TO BE COMPLETED BY MEMBER

PART (A): PATIENT INFORMATION

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

1a. Soc. Sec. No. _____

2. PATIENT'S DATE OF BIRTH

Month Day Year

3. PATIENT'S RELATIONSHIP TO MEMBER

☐ Self ☐ Spouse ☐ Child ☐ Step-child

4. PATIENT'S SEX

☐ Male ☐ Female

5. IS PATIENT A DEPENDENT AGE 19 OR OVER? ☐ Yes ☐ No

IF YES, HAVE YOU SUPPLIED FUND WITH MOST RECENT TAX RETURN? ☐ Yes ☐ No

6a. WAS INJURY OR CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B. ACCIDENT ☐ AUTO ☐ OTHER

6b. IF ACCIDENT, GIVE DATE _____

6c. HAS OR WILL LEGAL ACTION BE TAKEN? ☐ YES ☐ NO

6d. LAWYER'S NAME AND ADDRESS, IF ANY: _____

7. MEMBER MUST SIGN HERE. IF YOU ARE AUTHORIZING PAYMENT DIRECTLY TO PROVIDER YOU MUST ALSO SIGN LINE #8.

▶ _____

MEMBER SIGN HERE Dated

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

▶ _____

MEMBER SIGN ONLY IF APPLICABLE (SIGNATURE ON FILE NOT ACCEPTED) Dated

PART (B): MEMBER INFORMATION

1. MEMBER'S SOCIAL SECURITY NUMBER

2. MEMBER'S NAME AND ADDRESS

Last First

No. and Street Apt. No.

City State Zip Code

( )

Telephone No.

3. MEMBER'S EMPLOYER & JOB LOCATION WORK PHONE #

4. DATE OF BIRTH

MONTH DAY YEAR

SEX ☐ M ☐ F

5. CHECK ONE BOX ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

6a. Are you or your dependent/spouse covered under any other group plan? ☐ Yes ☐ No

6b. If yes, complete:

Name of person covered Relationship

Name and address of person's employer

6c. Plan name and I.D. number

6d. Effective date 6e. Termination date 6f. Coverage: Family/Indiv.

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

PART (C): PHYSICIAN OR SUPPLIER INFORMATION — Please complete all items

Effective May 1, 2000 – Local 94, 94A Participates with MAGNACARE PPO.

1. Date of First Treatment for Condition _____

2. Is this an initial consultation? ☐ Yes ☐ No

3. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No

3a. Is condition due to accident? ☐ Yes ☐ No

4. For service related to hospitalization, give hospitalization dates:

Admitted Discharged

Name of Hospital:

Surgery: ☐ Elective ☐ Emergency

(Submit Operative/Narrative Report)

5. Name and Address of Referring Physician

6. Will any claim for the services below be filed with any other insurance carrier or benefit provider? ☐ Yes ☐ No If Yes, please specify

Is patient's condition or treatment related to infertility? ☐ Yes ☐ No

7. Annual Physical ☐ Yes ☐ No

Diagnosis or nature of illness or injury (if diagnosis code other than ICD9*, give name) ICD9 CODE

1. Primary

2. Secondary

8. REPORT OF SERVICES (or attach itemized bill).

Date of Services	*Place of Services (See Codes Below)	Description of Surgical or Medical Services Rendered	Procedure Code, if used (if code other than CPT4 used, give name)	Charges

* DO-Doctor's Office IH-Inpatient Hospital NH-Nursing Home H-Patient's Home OH-Outpatient Hospital OL-Other Locations

8a. Are You a participant with MAGNACARE PPO? ☐ Yes ☐ No

TOTAL CHARGES $ _____

AMOUNT PAID $ _____

BALANCE DUE $ _____

9. Physician's name & degree (print) _____

10. Board Certified Specialty _____

11. Physician's signature _____

12. Date _____

13. Check to be made payable to _____ TI.N. or S.S. # _____

(W-9 MUST be on file with claims office to assign claim — T.I.N. and name MUST match exactly as it appears on I.R.S. records)

14. Street address _____ City _____ State _____ Zip _____

15. Telephone ( ) _____

For recommended elective surgery costing $1000.00 or more, complete reverse side. (PRIOR APPROVAL MANDATORY)

Furnishing of this blank is for the employee's convenience and is not an acknowledgment of liability or waiver of any right.

OVER

WHEN YOUR DOCTOR RECOMMENDS SURGERY:

THE COMPLETION OF THIS FORM IS **MANDATORY** FOR ELECTIVE SURGERY (NOT EMERGENCY) WHEN PERFORMED IN HOSPITAL, AMBULATORY SURGERY UNIT OR DOCTOR'S OFFICE AND COSTING OVER $1000.00 (NOT APPLICABLE FOR MEDICARE PATIENTS). A COPY OF OUR REPLY WILL BE SENT TO THE MEMBER AND THE DOCTOR INDICATING THE FUND ALLOWABLE BENEFIT AND IF A SECOND OPINION IS REQUIRED.

PLEASE NOTE: SECOND OPINIONS ARE NOT NECESSARY FOR EVERY PROCEDURE. THE FUND ALLOWS $100.00 FOR A SECOND OPINION VISIT WITH A DOCTOR OF YOUR CHOICE WHO IS **NOT** AFFILIATED WITH THE OPERATING SURGEON. CONTACT THE FUND OFFICE FOR A POSSIBLE REFERRAL TO A PARTICIPATING SECOND OPINION DOCTOR.

FAILURE TO COMPLY WITH THESE REQUIREMENTS WILL RESULT IN AN **AUTOMATIC** 30% FEE REDUCTION IN THE AMOUNT THE FUND ALLOWS FOR SURGERY, ASSISTANT SURGEON AND ANESTHESIA.

THIS FORM MUST BE COMPLETED AND RECEIVED IN FUND OFFICE AT LEAST 1 WEEK PRIOR TO SURGERY.

DOCTOR'S STATEMENT:

PATIENT NAME: _____ AGE _____

DIAGNOSIS: _____

SURGICAL PROCEDURE(S): _____

CPT CODES:	DESCRIPTION:	DOCTOR'S CHARGES:	MAXIMUM REIMBURSEMENT:
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____
(3) _____	_____	_____	_____
(4) _____	_____	_____	_____

INTENDED DATE OF PROCEDURE: _____ ASSISTANT SURGEON NEEDED ☐ YES ☐ NO

ASSISTANT REIMBURSEMENT IS ALWAYS DETERMINED AFTER SURGERY, ONCE THE OPERATIVE REPORT HAS BEEN REVIEWED BY THE FUND'S MEDICAL CONSULTANTS. WE ARE UNABLE TO DETERMINE OUR ALLOWABLE AMOUNT AT THIS TIME.

SURGEON NAME: _____ SIGNATURE: _____

SPECIALTY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

The Patient indicated on the front of this form is eligible for medical benefits up to _____.

Eligibility is determined each calendar quarter. If you require an update of the patient's eligibility then you are welcome to contact the Health & Benefit Fund office at (212) 307-1585 or (212) 541-9880.

Services and amounts were considered based on information available at the time of the pre-authorization, and any change in services would require additional review.

Pre-authorization Approved _____ NOT Approved _____ By _____ Date _____

NOTE TO MEMBER: See above for the approved maximum allowances. Based on the information supplied, it has been determined that a second opinion ☐ **will** ☐ **will not** be required.

If you have any questions please contact the FUND OFFICE immediately at (212) 307-1585.
To Expedite You May Fax This Pre-Surgical Form ONLY — (212) 245-7886