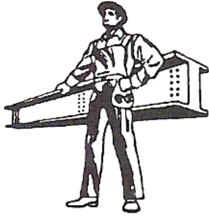

IRON WORKERS' Tri-State Welfare Fund

18861 90th Ave, Suite A
Mokena, Illinois 60448
Toll-Free 866-463-9418
Fax 630-967-3080
www.tristatewelfarefund.com
tristate@abpa-tpa.com

MEMBER'S STATEMENT

PROCESSING OF CLAIMS REQUIRES THAT YOU COMPLETE THIS FORM AS FOLLOWS:

- **YOU MUST COMPLETE AND SUBMIT SECTION 1 OF THIS FORM ONCE A YEAR OR YOUR CLAIM PAYMENTS MAY BE DELAYED.**
- **IF THIS IS FOR A DISABILITY CLAIM, YOU MUST COMPLETE SECTIONS 1 AND 4 AND YOUR PHYSICIAN MUST COMPLETE PAGE 2.**
- **IF THIS IS FOR A HEALTH CARE CLAIM THAT WAS NOT SUBMITTED BY A PROVIDER, YOU MUST COMPLETE THE ENTIRE FIRST PAGE AND HAVE YOUR PHYSICIAN COMPLETE THE SECOND PAGE OR ATTACH ITEMIZED BILLS AND (IF APPLICABLE) CORRESPONDING "EXPLANATION OF PAYMENT" STATEMENTS FROM MEDICARE OR PRIMARY INSURANCE. DO NOT SUBMIT BALANCE DUE STATEMENTS.**

Section 1: EMPLOYEE INFORMATION	Home Local Union No. ______
Name of Employee______	Date of Birth ______
Home Address ______	
City______ State ______ Zip Code ______	Telephone Number ( ) ______
Email______	
Social Security No. ______ Occupation ______	❑ Active ❑ Retired Date ______
Marital Status ❑ Single ❑ Married ❑ Separated ❑ Widowed	Date of Social Security Award ______
Note: If recently married or divorced, indicates date(s) ______	
OTHER INSURANCE INFORMATION NOTE: ATTACH COPY OF PAYMENT WORKSHEET FROM OTHER INSURANCE OR MEDICARE	
Do you **or** your dependents have **ANY** other health insurance? ❑ Yes ❑ No If **YES**, please supply:	
1. Name of the person insured ______	Relationship to Employee: ______
2. Insured person's Social Security No. ______	Date of Birth______
3. Insurance Company Number ______	Telephone Number ( ) ______
4. Address, City, State, Zip ______	
Section 2: DEPENDENT INFORMATION — If claim is for a Dependent	
Name of Dependent ______ Relationship to Employee ______	Date of Birth ______
SECTION 3: SICKNESS/INJURY INFORMATION REQUIRED FOR ALL CLAIMS	
Nature of sickness or injury ______	
Date accident occurred or sickness first began: ______	Date first treated ______
If injured, describe **HOW** and **WHERE** accident occurred ______	
If patient required treatment in hospital, indicate date treated next to type of treatment:	
1. Emergency Room ______ 2. Outpatient Surgery ______	3. Admission – Discharge ______
Name of Hospital ______ City ______	State ______
Name of physician(s) ______	City ______ State ______
Did injury or sickness occur in the course of **ANY** employment? ❑ Yes ❑ No	Have you or do you intend to file this claim under Workers' Compensation? ❑ Yes ❑ No
SECTION 4: EMPLOYEE MUST COMPLETE IF APPLYING FOR DISABILITY BENEFITS	
Employee's Disability Statement	Date Last Worked ______ Date Work Resumed ______ Might claim be covered by Workers' Compensation Law? ❑ Yes ❑ No
SECTION 5: AUTHORIZATION	
I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representatives, of any facts and/or related records concerning the injury, illness, or treatment (including mental/nervous and substance abuse) related to my dependents or myself. A photocopy of this authorization shall be considered as effective and valid as the original.	
Signed ______	Dated ______

ATTENDING PHYSICIAN'S STATEMENT

Patient's name and address: ____ Age_________

Insured Name, if patient is dependent: ____

PHYSICIAN OR SUPPLIER INFORMATION

Is condition due to injury or sickness? ❑Yes ❑ No If yes, explain

____

Is condition due to an accident? ❑Yes ❑ No If yes, explain

____

When did symptoms first appear or accident happen: Date: ______________________________

When did patient first consult you for this condition: Date: ______________________________

Has patient ever had same or similar condition? ❑Yes ❑ No If yes, when and describe:

____

Name of Referring Physician or Other Source (e.g., public heath agency)	For services related to hospitalization, give hospitalization dates Admitted: Discharged:
Name and address of Facility where services were rendered (if other than home or office)	Was Laboratory worked performed outside of your office ❑ Yes ❑ No
Diagnosis or nature of illness or injury (Relate diagnosis to procedure in column 1. by reference numbers 1., 2., 3., etc. or Dx Code. 1. 2. 3.	EPSDI ❑ Yes ❑ No Family Planning ❑ Yes ❑ No

Date of Service	Place of Service	Fully Describe Procedure, Medical services or supplies		Diagnosis Code	Charges	Days or Units	T.O.S.	Leave Blank
		Procedure Code Identify	Explain unusual services or circumstances					

INCLUDE ALL CODE NUMBERS (CPI, ICD 9) AND SERVICE DESCRIPTION	Total Charges
	Amount Paid
	Balance Due
Is patient still under your care for this condition? If "no" give date your services terminated.	❑ Yes ❑ No Date: ____________________
How long was/will patient be continuously totally disabled (unable to work)? **If patient not released to return to work, date of NEXT appointment.**	From: ____________________ Thru:____________________ Date: ____________________
To your knowledge, does patient have other health insurance or health plan coverage?	❑ Yes ❑ No If Yes, identify: ____________________

____

Name (type or print attending physician's name) Degree Tax Identification Telephone

____

Street Address City or Town State Zip Code

____

______**Attending physician's signature** **Date**

Patient's or Authorized Person's Signature **I authorize the release of any medical information and or related records necessary to process this claim.**	***I authorize payment of medical benefit to Physician or Supplier for service described.***
Signed **Date**	***Signed (insured)*** ***Date***