INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 25 MARINE DIVISION
MEDICAL PLAN
461 State Route 33
Millstone Township, NJ 08535

MEDICAL CLAIM FORM

PLEASE PRINT

Section 1 to be Completed by Employee

(800) 548-6662

Employee's Last Name	First Name	Initial	Social Security No.	Date of Birth	Mo.	Day	Year

Address: No. & Street | City | State | Zip | Home Phone No.

Name of Employer | Are You Retired? Yes ☐ No ☐

Are You Currently Employed? Yes ☐ No ☐ If No, Give Date Employment Ended

IF CLAIM IS FOR SPOUSE OR CHILD	Name of Spouse or Child	Soc. Sec. No.	Sex	Relationship to Employee Spouse ☐ Child ☐	Date of Birth	Mo.	Day	Year

Is Spouse or Child Employed? Yes ☐ No ☐ If Yes, give name and address of employer

Do you, your spouse or your child have other group medical or hospital coverage? Yes ☐ No ☐ If Yes, give name and address of insurance co.

Is treatment for condition caused by an injury? If "yes" see reverse side — Yes ☐ No ☐ If yes, Where? Auto Acc ☐ At Work ☐ Other ☐ If other, describe

Date of Injury	Mo.	Day	Year

I authorize the physician and/or hospital to furnish Local 25 Medical Plan with information about my claim.

Employee MUST sign here _____ Date _____

I authorize payment of benefits directly to the physician or other provider of service and acknowledge that I will reimburse this Plan from any monies I receive in settlement or judgment against a 3rd party who caused the injury or illness.

Employee signs here if applicable _____ Date _____

Section 2 to be Completed by Practitioner

Name of PATIENT | Was patient referred to you by another physician? Yes ☐ No ☐ Name of referring physician:

Does condition or injury arise out of patient's employment? Yes ☐ No ☐ Pregnancy? Yes ☐ No ☐ If yes, approximate date pregnancy commenced: Date

Diagnosis or Nature of Illness or injury. Relate Diagnosis to Procedure in Column G by reference to numbers 1, 2, 3, etc., or DX code
1
2
3

A Date of Service	B* Place of Service	C Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given — Procedure Code**	C (Explain unusual services or circumstances)	D*** Type of Service	E Charges	F Days or Units	G**** Diagnosis Code

Signature of physician or supplier

Signed _____ Date _____

Your patient's account no.

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.

Total charge	Amount paid	Balance due

Physician's or supplier's name, address, zip code & telephone no.

*PLACE OF SERVICE CODES

1 - (H) - Inpatient hospital
2 - (OH) - Outpatient hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home

***TYPE OF SERVICE CODES

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnositic 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 on Elective Surgery

**PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR ALL SERVICES

****Please use ICD-9-CM For Diagnosis

IMPORTANT

THIS FORM MUST BE SENT TO THE ADMINISTRATOR NOT LATER THAN 90 DAYS FOLLOWING SURGERY, DISCHARGE FROM HOSPITAL, OR EMERGENCY TREATMENT.

If you are making a claim against a 3rd person or any entity for causing the injury or illness for which you seek benefits, the Local 25 Medical Plan will provide benefits only on condition that you agree to reimburse the Plan from any monies you recover by way of settlement or judgement against any such 3rd person or entity.

You must advise your attorney who is representing you in your claim against a 3rd person of your obligation to reimburse the Plan. Please refer to the Plan's provision on subrogation and reimbursement for full information. If you need a copy of this provision, please contact the Plan office.

Note that we may require you, the injured person and your attorney to sign an agreement concerning the Plan's subrogation and reimbursement rights in order for the Plan to pay benefits related to this illness or injury. Contact the Plan office for additional information.

Please furnish the following information:

1. Date and Place of Injury

_____ _____

Date Place

2. Name of person or entity against whom you are making the claim.

_____

3. Name and address of your attorney.

_____

Name

_____

Address