



IRON WORKERS'

Tri-State Welfare Fund

333 Pierce Road, Suite 410
 Itasca, Illinois 60143
 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 FULLY COMPLETE THIS FORM.

Have your physician or provider complete the next page of this form or attach itemized bills AND (if applicable) corresponding "Explanation of Payment" statements from Medicare or primary insurance. **DO NOT SUBMIT BALANCE DUE STATEMENTS.**

MEMBER INFORMATION		Home Local Union No. _____
Name of Employee _____	Date of Birth _____	
Home Address _____		
City _____ State _____ Zip Code _____	Telephone Number () _____	
Social Security No. _____ Occupation _____	<input type="checkbox"/> Active <input type="checkbox"/> Retired Date _____	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please supply:		
1. Name of the person insured _____	Relationship to Employee: _____	
2. Insured person's Social Security No. _____ Date of Birth _____	Date of Birth _____	
3. Insurance Company Number _____	Telephone Number () _____	
4. Address, City, State, Zip _____		
DEPENDENT INFORMATION — If claim is for a Dependent		
Name of Dependent _____ Relationship to Employee _____	Date of Birth _____	
Is Dependent attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Dependent employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, where? _____
Name: _____		
Address, City, State, Zip _____		
Note: Attach letter from registrar of college/university indicating hours enrolled per semester.		
SICKNESS/INJURY INFORMATION REQUIRED FOR ALL CLAIMS*		
Nature of sickness or injury _____		
Date accident occurred or sickness first began: _____	Date first treated _____	
If injured, detailed described of 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you or do you intend to file this claim under Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MEMBER MUST COMPLETE IF APPLYING FOR DISABILITY BENEFITS		
Member's Disability Statement _____	Date Last Worked _____ Date Work Resumed _____	Might claim be covered by Workers' Compensation Law? <input type="checkbox"/> Yes <input type="checkbox"/> No * Next page of this form MUST be completed by Employee's Physician
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) of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.		
Signed _____		Dated _____

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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 health 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 work performed outside of your office? <input type="checkbox"/> Yes <input type="checkbox"/> 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. _____ 4. _____	EPSDI <input type="checkbox"/> Yes <input type="checkbox"/> No Family Planning <input type="checkbox"/> Yes <input type="checkbox"/> 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 (CPT, ICD 9) AND SERVICE DESCRIPTIONS	Total Charge	Amount Paid	Balance Due
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Is patient still under your care for this condition? If "no" give date your services terminated.	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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. _____ Signed _____ Date _____	I authorize payment of medical benefit to Physician or Supplier for service described. _____ Signed (insured) _____ Date _____
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