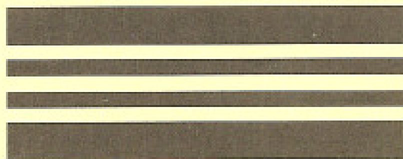
MEDICAL CLAIM FORM

The Union Labor Life Insurance Company



Communications Workers Local 1109
Welfare Fund
Tel. No.: (718) 444-1119
c/o The Union Labor Life Insurance Company
P.O. Box 61593
King of Prussia, PA 19406
(Toll Free) Tel. No.: 1-877-800-2956

Member's Name (print in full)	Policy or Plan No. **C-3968**	Social Security Number
Home Address	Date of Birth	Daytime Phone Number
City State Zip	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed	Work Status ☐ Active ☐ Disabled ☐ Retired ☐ Other (specify)

PATIENT INFORMATION

Name Social Security Number	Date of Birth
Relationship to Member ☐ Self ☐ Spouse ☐ Child* ☐ Other (specify)	Sex ☐ Male ☐ Female

*If Child: Married? ☐ Yes ☐ No Full-time Student? ☐ Yes ☐ No

Medicare Coverage — Effective Date
☐ Hospital (Part A) only ☐ Both (A & B)
☐ Medical (Part B) only ☐ None

SPOUSE INFORMATION

Name	Date of Birth
Social Security Number	Employment Status ☐ Active ☐ Retired ☐ Not Employed
Employer Name and Address	

Describe sickness or injury. If injury, where and how did it occur?

Date sickness began or injury occurred	Did injury occur at work? Was sickness caused by work? ☐ Yes ☐ No	Was injury caused by an automobile accident? If yes, specify city & state above. ☐ Yes ☐ No

IF YOU OR ANY MEMBER OF YOUR FAMILY IS COVERED UNDER ANOTHER GROUP HEALTH PLAN, COMPLETE THE FOLLOWING SECTION.

Covered Family Member ☐ Self ☐ Patient ☐ Spouse ☐ Other: specify Name and Relationship			Name and Address of Insurance Company
Policy or Plan No.	Insurance ID Number	Type of Coverage ☐ Individual ☐ Family	

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

AUTHORIZATION FOR RELEASE OF INFORMATION: I/We authorize the release to ULLICO and its agents of any evidence or information about me or my dependents that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original. (Patient's signature is required if patient is a legal adult.)

Member's Signature Date Patient's Signature Date

INSTRUCTIONS FOR MAKING CLAIM FOR BENEFITS 1. Answer all required questions on this side of form, and sign it.
2. If you want us to pay the hospital or doctor directly, sign the "Assignment of Benefits" section on the reverse.
3. Have the doctor complete his section or attach an itemized bill indicating the patient's name, diagnosis, the type, place and date of each service, and the amount charged.

THIS SECTION TO BE COMPLETED BY POLICYHOLDER	
Member Efective Date	Member Termination Date
I certify that the patient named in this claim was eligible for medical benefits during the period spcified above. Policyholder's Representative Date	

CLM-9

EMPLOYER/DISABILITY INFORMATION

1. From what date was he continuously employed?
2. On what date did he last work prior to his disability? Wkly. Wage $
3. Is this disability a result of injury or occupational disease arising out of or in the course of employment?
4. If the cause of disability was occupational, has it been reported to the state board or commission or to any insurance company as a workmen's compensation claim?

   If not, please state the reasons:

5. If the employee has returned to work, please indicate exact date

Name of employer

Employer's tax I.D. number By

Address of employer

ASSIGNMENT OF BENEFITS	I authorize payment of benefits to the undersigned physician or supplier for the services described below. Member's Signature Date

PHYSICIAN OR SUPPLIER INFORMATION: These sections to be completed by physician unless claim is submitted with an itemized bill.

		IF PATIENT IS/WAS UNABLE TO WORK:
Patient's Name (print in full)		Date patient able to return to work
Date of Illness (first symptoms), injury (accident), or Pregnancy (LMP)	Date first consulted for this condition	Dates of total disability from through
Has patient ever had similar symptoms? ☐ Yes ☐ No If Yes, When?		
Referring Physician		Dates of partial disability from through
Facility where services were rendered (if other than home or office)		

ICDA CODES AND DESCRIPTIONS OF DIAGNOSES: Relate to services below with numbers at left	HOSPITALIZATION. Use UB-92 codes.		
①	Admission Date	Type Code	Source Code
②	Discharge Date	Discharge Status Code	
③			

↓	PLACE OF SERVICE*	PROCEDURE (CPT/RVS)	DESCRIPTION OF PROCEDURE, SERVICE, OR SUPPLY FURNISHED Explain unusual services or circumstances	DATES OF SERVICE From To	DAYS/ UNITS	CHARGES

Physician's or Supplier's Name, Address, and Telephone Number (print)	Patient's Account Number	Total Charges
	Physician's Tax ID Number	Amount Paid
		Balance Due

ULLICO WILL NOT ACCEPT AN ASSIGNMENT OF BENEFITS WITHOUT THE PHYSICIAN'S OR SUPPLIER'S TAX IDENTIFICATION NUMBER

*** PLACE OF SERVICE CODES**

(1) Inpatient Hospital	(5) Day Care Facility	(9) Ambulance
(2) Outpatient Hospital	(6) Night Care Facility	(10) Other Locations
(3) Doctor's Office	(7) Nursing Home	(11) Independent Laboratory
(4) Patient's Home	(8) Skilled Nursing Facility	(12) Non-Hospital Surgical Ctr.

Physician's Signature Date