U.A. Local #350 Health, Welfare, and Vacation Trust Funds

Mail Claims to: Post Office Box 11337 . Reno, NV 89510
Street Address: 445 Apple Street, Suite 109 . Reno, Nevada 89502
(775) 826-7200

MEDICAL CLAIM FORM

Employee Information

Employee's Name (Last Name)	(First Name)	(M.I.)	Gender ☐ M ☐ F	Date of Birth

Employee's Address (No., Street)	(City)	(State)	(ZIP code)	Telephone # ( )

IS THIS A CHANGE OF ADDRESS? ☐ Yes ☐ No Please submit a new enrollment form if you answered YES.	Social Security Number or Alternate I.D.	Local Union # and Employer Name

Patient Information

Patient Name (Last Name)	(First Name)	(M.I.)	Gender ☐ M ☐ F	Date of Birth

Patient's Address – If different than Employee address (No., Street)	(City)	(State)	(ZIP code)

Relationship to Employee
☐ Spouse ☐ Child ☐ Stepchild ☐ Other

Accident Claim Information:

Complete this section only if you are filing the claim because of an accident or injury.

Is This an Accident? ☐ Yes ☐ No	Is Accident or Injury Employment Related? ☐ Yes ☐ No	Is Injury Due to Auto Accident? ☐ Yes ☐ No	Are you or your dependents filing a claim or lawsuit against a Third Party including an insurance company in order to recover the cost of expenses incurred as a result of this accident or injury? ☐ Yes ☐ No If yes, Name of Third Party

Date of Accident or Injury	Description of how accident or work-related injury occurred

Family/Other Coverage Information:

Complete only if claim is for a dependent and/or other coverage is in effect.

Spouse Employed? ☐ Yes ☐ No	If no, has spouse been employed the last 12 months? ☐ Yes ☐ No	Name of Spouse (Last Name)	(First Name)	(M.I.)

Spouse's Date of Birth	Name of Spouse's Employer	Employer Telephone # ( )

Spouse's Employer Address (No., Street)	(City)	(State)	(ZIP Code)

Is the patient covered under another Health Insurance Plan? ☐ Yes ☐ No	If yes, provide Name of Health Insurance Company and the effective date of coverage.	Policy Number	Type of Plan (HMO or PPO) if Known

Are Dependants Covered? ☐ Yes ☐ No Is the patient covered under Medicare? ☐ Yes ☐ No

If you answered yes to patient being covered by another Health Insurance and the other insurance is primary, then please send us this form and (a) a copy of the explanation of benefits (EOB) and (b) the itemized bill(s) for this claim.

Release of Information

I authorize any medical information relating to this Claim to be disclosed to and acquired by the Administrator of this Plan and such agents of the Administrator as are necessary to process this Claim. Such information may be disclosed by a Health Care Provider or other Plan Administrator, and will be used for the purpose of processing this Claim. This authorization shall remain valid until the Claim is paid; the information shall be retained by the Administrator if required by law. Any person who knowingly files a statement of Claim containing any false or misleading information is subject to **Criminal and Civil Penalties in Certain States.** Upon request, the patient shall be furnished with a copy of this authorization.

Patient's Signature (Parent or Guardian's Signature if Patient is a minor) _____ Date _____

Payment Instructions

Payment Authorization: Pay Member ☐ Pay Provider ☐
I authorize the Administrator to make payment directly to the health care professional listed on the enclosed bills.

Employee's Signature _____ Date _____

I hereby certify that the foregoing statements including any accompanying statements are to the best of my knowledge believed to be true and correct.

Employee's Signature _____ Date _____