

# HEALTH PLAN BENEFITS

HARRISON ELECTRICAL WORKERS TRUST FUND

1220 S.W. Morrison, Suite 300

Portland, OR 97205-2222

In Portland Area (503) 224-0048

All Other Locations 1-800-547-4457

**PART 1: MUST BE COMPLETED BY EMPLOYEE**

1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME, ADDRESS AND PHONE NO.	
FULL TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE				
4. PATIENT'S ADDRESS (if different from employee)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. EMPLOYEE'S SOC. SEC. NO.	
9. IS PATIENT ALSO COVERED BY ANOTHER GROUP HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, List Plan Name, Employer and Address		7. PATIENT'S RELATIONSHIP SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. EMPLOYER LOCATION	
		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	11. IF AN ACCIDENT <input type="checkbox"/> A.M. date _____ 20____ and time _____ <input type="checkbox"/> P.M. description (how & where) _____	

<b>12. AUTHORIZATION TO RELEASE INFORMATION</b>		<b>13. AUTHORIZATION TO PAY BENEFITS TO PROVIDERS</b>	
<b>PATIENT OR PARENT RELEASE SIGN BELOW</b> I hereby authorize any insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.  X _____ PATIENT OR PARENT (IF MINOR) DATE		<b>IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW</b> I hereby authorize payment of benefits directly to any providers of services, but not to exceed the usual, reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.  X _____ EMPLOYEE DATE	

**PART 2: TO BE COMPLETED BY PHYSICIAN (OR ATTACH ITEMIZED BILL)**

14. DATE OF:	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES <input type="checkbox"/> NO <input type="checkbox"/>	

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

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24. A DATE OF SERVICE	B* PLACE OF SER- VICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F
		PROCEDURE CODE* (Identify)			

25. SIGNATURE OF PHYSICIAN OR SUPPLIER		26. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER.	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNED	DATE		30. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		

- \* PLACE OF SERVICE CODES
- |                                    |                               |                                      |                                   |
|------------------------------------|-------------------------------|--------------------------------------|-----------------------------------|
| 1 - (IH) - INPATIENT HOSPITAL      | 4 - (H) - PATIENT'S HOME      | 7 - (NH) - NURSING HOME              | O - (OL) - OTHER LOCATIONS        |
| 2 - (OH) - OUTPATIENT HOSPITAL     | 5 - DAY CARE FACILITY (PSY)   | 8 - (SNF) - SKILLED NURSING FACILITY | A - (IL) - INDEPENDENT LABORATORY |
| 3 - (O) - DOCTOR'S OFFICE FACILITY | 6 - NIGHT CARE FACILITY (PSY) | 9 - AMBULANCE                        | B - OTHER MEDICAL/SURGICAL        |

**IF FILING A CLAIM FOR WEEKLY DISABILITY BENEFITS, #14-30 MUST BE COMPLETED BY YOUR PHYSICIAN**

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### THIS SECTION TO BE COMPLETED BY EMPLOYER (IF CURRENTLY EMPLOYED) OR UNION (IF NOT DISPATCHED) IF LOSS OF TIME IS INVOLVED

Date Employee Stopped work	Has employee returned to work? Yes <input type="checkbox"/>	No <input type="checkbox"/>		
	When?	When expected?		
Date:	Employer or Union	By	Title	
Mailing Address	Street	City	State	Zip

## INSTRUCTIONS

BE CERTAIN TO VERIFY THAT RESERVE HOURS ARE SUFFICIENT TO WARRANT COVERAGE. THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE AND THE ATTENDING PHYSICIAN

Be Sure ALL questions are answered and ALL information requested is furnished.

For WEEKLY BENEFIT CLAIMS, the Employer or Union Business Manager must also compete and sign the above.

The Attending Physician's Statement on the reverse side MUST be completed.

Attach ITEMIZED bills from Hospital, Attending Physician, Surgeon, Etc. if claim is filed for these benefits.

## HOW TO REQUEST BENEFITS

1. COMPLETE THE "PATIENT INFORMATION" (ITEMS 1 THROUGH 12) ON THE REVERSE SIDE OF THIS FORM.  
If you wish your benefits to be paid directly to your physician, sign item 13.
2. HAVE YOUR PHYSICIAN COMPLETE THE "PHYSICIAN OR SUPPLIER INFORMATION"; OR ATTACH ITEMIZED BILL.
3. ATTACH THE COMPLETED "BENEFIT REQUEST FORM" TO THE BILLS AND MAIL THEM TO THE PLAN ADMINISTRATOR AT THE ADDRESS BELOW.
4. A SEPARATE FORM MUST BE SUBMITTED FOR EACH FAMILY MEMBER FOR WHOM A CLAIM FOR BENEFITS IS BEING MADE.

## WHERE TO FILE A CLAIM:

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## TO CHECK YOUR ELIGIBILITY – CALL THE ADMINISTRATION OFFICE

In Portland Area (503) 224-0048  
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