I.B.E.W. LOCAL 697 ACCIDENTAL INJURY CLAIM FORM

Failure to complete this form in its entirety may result in a delay in processing this claim.

☐ Complete Policyholder/Patient Information and sign your claim form.
☐ Have the treating physician complete Section B: Physician's Statement and sign the claim form **or**
☐ If hospitalized and/or confined to an intensive care unit/step-down unit, please send a copy of your hospital bill showing charges and the number of days you were confined. These items can be obtained directly from your healthcare provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (non-hospital bill).
☐ If you are filing for disability, please complete the Initial Disability Claim Form (NY-S00224) as well. **Forms are available on our web site at ibew697benefits.com.**

Policyholder Information
(Please print.)

Medical ID Number _____

First Name _____ Initial ____ Last Name _____

Mailing Address _____

City _____ State _____ ZIP _____

Check box if this is a new permanent address: ☐

Social Security Number _____ Phone Number _____

Patient Information
(Please print.)

First Name _____ Initial ____ Last Name _____

Relationship:
☐ Primary Policyholder ☐ Spouse

Sex:
☐ Male ☐ Female

Patient Birth Date: _____

☐ Dependent Child ☐ Check here if dependant child is a full-time student (if over the age 19, please provide school name and contact information).

Please answer the following questions. The claim cannot be processed until all necessary information is provided:

Date of accident: _____ Describe how the accident happened: _____

_____

Location of the accident? ☐ On the job ☐ Off the job ☐ Other (please describe): _____

Was the patient the driver in a motor vehicle accident? ☐ Yes (Attach the police report) ☐ No

☐ I am wholly unable to physically engage in any type of work.

I have returned to work and did so on _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____ _____

CLAIMANT SIGNATURE **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** **DATE**

The Lake County Indiana, N.E.C.A. - I.B.E.W. Health and Benefit Plan
Attention: Claims Department • 7200 Mississippi Street, Suite 300 • Merrillville, IN 46410
For information or help filing your claim, please call 1-219-940-6181 or visit our Web site at ibew697benefits.com
Fax number 1-219-844-1799

ACCIDENTAL INJURY CLAIM FORM – PHYSICIAN'S STATEMENT

Failure to complete this form in its entirety may result in a delay in processing this claim.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Medical ID#: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

SECTION B: PHYSICIAN'S STATEMENT **Please answer each question COMPLETELY.**

Physician's Name	Phone Number ( )	Fax Number ( )
Mailing Address	City	State ZIP

DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION

Date of incident: _____/_____/_____ Describe where and how the incident occurred: _____

_____

_____

Was the patient referred to you by another physician? ☐ Yes ☐ No

If yes, physician's name: _____

Referring physician's address: _____ Phone number: _____

Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No

Admission: _____/_____/_____ Discharge: _____/_____/_____

Hospital Name: _____

City: _____ State: _____

PHYSICIAN'S SIGNATURE **DATE** **TAX ID NUMBER**

The Lake County Indiana, N.E.C.A. - I.B.E.W. Health and Benefit Plan
Attention: Claims Department • 7200 Mississippi Street, Suite 300 • Merrillville, IN 46410
For information or help filing your claim, please call toll-free 1-219-940-6181 or visit our Web site at ibew697benefits.com. Fax number 1-219-844-1799

Claims Authorization to Obtain Information

Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. **All areas of this form should be completed.**
2. **This form must be signed and dated by the claimant / patient below.**
3. **If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/ patient. In addition, if not already on file, include a copy of the legal document(s) authorizing you to act on their behalf.**
4. **Fax this form to 1-219-844-1799 or return the form to the Lake County Indiana, N.E.C.A. - I.B.E.W. Health and Benefit Plan, Attn: Claims Department, 7200 Mississippi Street, Suite 300, Merrillville, IN 46410 as soon as possible to expedite the review of your claim.**

Policyholder Name:	**Medical ID Number:**	**Date of Birth:**
Policyholder Address:		
Claimant/Patient Name (if different from named policyholder listed above):		**Date of Birth:**

Name and Address of health care provider(s), company, or individual authorized to release the requested information:

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:

Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to the Lake County Indiana, N.E.C.A. - I.B.E.W. Health and Benefit Plan or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (such as, but not limited to the Plan's stop loss insurance provider)

I understand that:

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to the Lake County Indiana, N.E.C.A. - I.B.E.W. Health and Benefit Plan, Attn: Claims Department, 7200 Mississippi Street, Suite 300, Merrillville, IN 46410, except to the extent that:
    a. The Plan has taken action in reliance to this authorization, or
    b. Other law provides the Plan with the right to contest a claim under the provisions of the Plan.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative **Date**

Printed name of claimant/patient, guardian or authorized representative **Relationship**