

ILWU-PMA WELFARE PLAN

CHIROPRACTIC BENEFIT CLAIM FORM

This form is for use by Welfare Plan eligibles enrolled in:

- **Kaiser Plans**
- **Group Health Cooperative**

TO BE COMPLETED BY EMPLOYEE:

Employee Name _____ Local _____ Reg. No. _____

Member ID: _____ Phone: (____) _____

Address _____
Street _____ City _____ State _____ Zip Code _____

Patient's Name, if not Employee _____ Patient's Date of Birth _____ Relation to Employee _____

1. Is patient covered for chiropractic benefits by any other group insurance or health service plan? YES NO
2. Is patient eligible for Medicare?
If YES, attach Medicare EOMB. YES NO
3. Is patient's condition due to an accident, injury or illness arising out of employment? YES NO
4. If answer to No. 3 is YES, has patient filed or does patient intend to file a claim for benefits under any federal or state workers' compensation law? YES NO
5. Is patient's condition due to an accident, injury or illness caused by some other party? YES NO
6. If answer to No. 5 is YES, has patient filed or does patient intend to file any legal action or claim against the other party? YES NO

I authorize release to the Trustees, their agents and their consultants any and all information pertaining to chiropractic care rendered to me or my dependents.

Employee Signature _____ Date _____

ASSIGNMENT OF BENEFITS (OPTIONAL):

To be completed and signed by employee if payment of benefit directly to provider of chiropractic care is desired.

- I hereby assign my Welfare Plan Chiropractic Benefits to the Chiropractor(s) indicated hereon.

Employee Signature _____ Date _____

(over)

TO BE COMPLETED BY CHIROPRACTOR:

Patient's Name _____

First visit for this condition

Repeat visit - date first treated for present condition _____

Diagnosis _____
and/or
Symptoms _____

To your knowledge, is patient's condition due to an accident, injury or illness arising out of employment? YES NO

If YES, please explain _____

To your knowledge, is patient's condition due to an accident, illness or condition caused by some other party? YES NO

If YES, please explain _____

Is treatment continuing? YES NO

Please attach itemized bill, or itemize below:

<u>Date</u>	<u>Nature of Service</u>	<u>RVS No.</u>	<u>Your Charge to Patient</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Attending Chiropractor _____
Please print name

Address _____
Street City State Zip Code

Federal Tax No. _____ Telephone _____

Signed _____ Date _____

MAIL COMPLETED FORM TO: ILWU-PMA Coastwise Claims Office
Chiropractic Benefit Program
814 Mission Street, Suite 300
San Francisco, CA 94103
Ph: (800) 955-7376 or (415) 543-0114

MEDICARE ELIGIBLES MUST ATTACH MEDICARE EOMB