ILWU-PMA COASTWISE INDEMNITY PLAN
Hospital, Medical, and Surgical Benefit Claim Form

Employee to fill out Part 1. Have your doctor fill out Part 2
Note: For Hospital Benefits attach itemized bill.

PART 1 – EMPLOYEE STATEMENT

1. Name of Employee:	2. Local Number:	3. Registration Number:	4. Member ID Number	5. Single ☐ Married ☐

6. Address (Street, City, State & Zip Code):

7. Name of Patient if not Employee:	8. Patient's Date of Birth:

9. Patient's Relationship to Employee:	10. If Child, indicate: Male ☐ Female ☐	11. If Married, is Spouse Employed: Yes ☐ No ☐	12. If yes, Spouse's Social Security Number:

13. Spouse's Employer:	14. Address (Street, City, State & Zip Code):

15. Is the patient covered by any other group insurance or health service plan? Yes ☐ No ☐	16. If yes, provider Policy Number:	17: Name of Other Plan:

18. Address of Other Plan (Street, City, State & Zip Code):

19. Do you have Medicare Insurance? Part A: Yes ☐ No ☐ Part B: Yes ☐ No ☐ Effective Date: _____	20. Does your spouse or any of your children have Medicare Insurance? Part A: Yes ☐ No ☐ Part B: Yes ☐ No ☐ Name: _____ Effective Date: _____
21. Is patient's condition due to any accident, injury, or illness arising out of employment? Yes ☐ No ☐	22. If answer to #21 is yes, have you or the patient filed or do you intend to file a claim for benefits under any Federal or State Workers' Compensation Law? Yes ☐ No ☐
23. Is patient's condition due to an accident, injury, or illness caused by some other party? Yes ☐ No ☐	24. If answer to #23 is yes, have your or the patient filed or do you intend to file any legal action or claim against the other party? Yes ☐ No ☐
25. Is patient's condition due to an accident? Yes ☐ No ☐	26. If answer to #25 is yes, how, when (date), and where?

The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union, or association to release information to ILWU-PMA COASTWISE CLAIMS OFFICE as is required to properly pay all benefits due me or my dependents:

Employee Signature: _____ Date: _____

PAY TO PROVIDER (*Optional)*

If you want benefits paid to the provider of care, this section must be signed and dated by the employee:

Employee Signature: _____ Date: _____

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PART 2 – PHYSICIAN'S STATEMENT

1. Patient's Name:

2. Diagnosis and/or Dx Code:
   (a) Is patient's condition due to accident? Yes ☐ No ☐ If yes, give date: _____
   (b) Is patient's condition due to an accident, injury or illness at place of employment? Yes ☐ No ☐
   (c) Is patient's condition due to an accident, injury or illness caused by some other party? Yes ☐ No ☐

3. Date patient first treated for present condition:

4. Is treatment continuing: Yes ☐ No ☐

5. Surgical Procedure(s) performed: | Date: | Date:

6. Confined Hospital Name: | From: | To:

7. Is patient disabled (unable to perform usual activities)? Yes ☐ No ☐
   If yes, give date: From: _____ To: _____

8. Please attach itemized bill. In lieu of itemized bill, itemize charges below:

DOS	POS	Treatment Diagnosis / Description	Diagnosis Code	CPT Code	YOUR CHARGE TO PATIENT
					$
					$
					$
					$

9. To your knowledge, does patient have other Health Insurance or Health Service Plan Coverage:
   Yes ☐ No ☐ If yes, please identify: _____

Treating Physician(s): _____ M.D.
(Please Print Name)

Federal Tax Number:

Address: _____
(Street, Apt. #)

_____
(City) *(State)* *(Zip Code)*

Telephone Number:

Physician Signature:

Date:

HOW TO FILE YOUR CLAIM:

(1) Member: Fill out and sign Page 1
(2) Provider: Fill out and sign Page 2. In lieu of page 2, submit a fully itemized bill issued by the provider of service
(3) Attach other isurance payment information if applicable
(4) Mail to: ILWU-PMA COASTWISE CLAIMS OFFICE
P.O. Box 429101, San Francisco, CA 94142