PLEASE READ INSTRUCTIONS BELOW
BEFORE COMPLETING THE CLAIM FORM ON OTHER SIDE.

INSTRUCTIONS

 Employee, prescribing physician, and dispenser of durable equipment must complete this form.

 Attach itemized bill and receipt. Medicare eligibles must also attach a copy of the Medicare explanation of benefits denying the payment.

 Mail completed form to: ILWU-PMA Benefit Plans
  1188 Franklin Street – Suite 101
  San Francisco, CA 94109

NOTE: Not more than one Blood Sugar Monitor is provided per family. To verify eligibility for a benefit, contact the Benefit Plans office.
Part I. - Employee Statement:

1. Employee __________________________ Local _______ Registration No. ____________
   (or Survivor) (PLEASE PRINT)

2. Address __________________________________________
   (Street) __________________________________________
   (City) __________________________ (State) _______ (Zip Code) ____________

3. Patient __________________________ Relationship to Employee _______

4. Has Employee (or Survivor) filed a prior claim for Diabetic Durable Equipment benefit?  
   □ YES  □ NO
   If answer is yes, date of claim ___________ / ___________ / ___________

5. Employee’s Signature __________________________ Date ___________ / ___________ / ___________
   (or Survivor’s) __________________________
   Telephone Number (optional): (___________)

Part II. - Physician’s Statement:

I hereby certify that I have prescribed a Blood Sugar Monitor for the purpose of self-administered blood sugar testing for
(Patient) __________________________
I further certify this equipment to be medically necessary for monitoring a permanent condition.

Physician (PLEASE PRINT) __________________________
Address __________________________________________
   (Street) __________________________________________
   (City) __________________________ (State) _______ (Zip Code) ____________

Signature __________________________ Date ___________ / ___________ / ___________

Part III. - Diabetic Durable Equipment Dispenser (Dealer): (Benefit is not assignable.)

Blood Sugar Monitor was purchased on ___________ / ___________ / ___________ for (Patient) __________________________
Equipment Description __________________________ Total Charge $ ___________

Dispenser __________________________
   (Name) __________________________
   (Address) __________________________

Authorized Signature __________________________ Date ___________ / ___________ / ___________

PLEASE PROVIDE ITEMIZED BILL AND RECEIPT.

PLAN OFFICE USE ONLY

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<td>Patient Code: 1 2 3</td>
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