ILWU-PMA WELFARE PLAN

CHIROPRACTIC BENEFIT CLAIM FORM

This form is for use by Welfare Plan eligibles enrolled in **Kaiser Plans.**

TO BE COMPLETED BY EMPLOYEE:

Employee Name_____ Local_____ Reg. No._____

Member ID: _____Phone: (_____)_____Email Address:_____

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 authorize Welfare Plan Chiropractic Benefit payments to be made directly 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:

Date	Nature of Service	RVS No.	Your Charge to Patient

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
P.O. Box 429101
San Francisco, CA 94142
Phone: (800) 955-7376

MEDICARE ELIGIBLES MUST ATTACH MEDICARE EOMB

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