IUPAT LOCAL 177 WELFARE TRUST FUND

SUPPLEMENTARY HEALTH CLAIM FORM

INSTRUCTIONS: Attach the original receipts for all expenses. Receipts will not be returned, as a copy of the Explanation of Benefits is sent to you and copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans.

Your claim will be returned to you if the claim form is incomplete.

1. MEMBER INFORMATION

PLAN SPONSOR / EMPLOYER NAME			GROUP NUMBER **5801**
LAST NAME	FIRST NAME		CERTIFICATE NUMBER/SIN
ADDRESS	GENDER ☐ Male ☐ Female	LANGUAGE ☐ English ☐ French	DATE OF BIRTH (MM/DD/YY)
CITY	PROVINCE	POSTAL CODE	PHONE NUMBER

2. PATIENT INFORMATION

Does the patient have any other coverage which would pay a benefit for this claim? ☐ Yes ☐ No

If yes, please indicate the date of birth of the insured:_____(MM/DD/YY)_____

If yes, attach photocopies of vision receipts and the co-insurance statement.

Is the treatment required as the result of an accident? ☐ Yes ☐ No

If yes, indicate the accident date, location and details on how the accident occurred. _____

_____

Is the treatment required as the result of a work related injury? ☐ Yes ☐ No

If yes, is a claim being made for Worker's Compensation benefits? ☐ Yes ☐ No

CLAIM DETAILS

Patient Name (Last, First)	Relationship to Member	Date of birth (MM/DD/YY)	Type of Service	Date of Service (MM/DD/YY)	Total Charges

TO ASSIGN PAYMENT TO SUPPLIER:

I hereby assign my benefits payable from this claim to _____ and authorize payment directly to the supplier.
(Name of Supplier)

_____

Member Signature

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Funds Administrative Service Inc. to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount.

SIGNATURE OF MEMBER DATE (MM/DD/YY)

Please return to:
Funds Administrative Service Inc.
10154 – 108 Street, NW, Edmonton, AB T5J 1L3
Phone (780) 452-5161 Toll free: 1-800-770-2998 Fax (780) 452-5388

PHYSICIAN'S RECOMMENDATION
(FOR MAJOR MEDICAL SUPPLIES)

1. Patient's Name _____
2. Recommended medical item(s) – describe in detail including specifications when available _____
3. Indicate activities requiring this item _____
4. Diagnosis of medical condition with specific reason for recommendation of medical item(s) _____

   _____
5. Condition of patient: ☐ Acute ☐ Chronic ☐ Palliative
6.
   a. Date patient first consulted you for this condition (month/day/year) _____
   b. Are you actively treating this patient for this condition ☐ Yes ☐ No If no, please provide comments

   _____

   _____
7. To the best of your knowledge, what is the duration for use of the recommended item(s) _____
8. For hospital beds only, please indicate the hours or percentage of time in bed _____
9. For replacement of a prosthesis or other equipment, please provide:
   a. Date of prior replacement (MM/DD/YY) _____
   b. Reason for replacement _____
10. Is the device(s) and/or medical equipment required:
    a. As a result of a work related injury? Yes ☐ No ☐
    b. As a result of a motor vehicle accident? Yes ☐ No ☐
    c. For sports purpose only? Yes ☐ No ☐
11. Has an application been made for government funding? ☐ Yes ☐ No If no, please give reason

    _____

_____ _____ General Practitioner
Physician's Name Physician's Signature Specialist

_____ _____
Date (MM/DD/YY) Phone Number

THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND ANY CHARGES MADE FOR ITS COMPLETION.

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