

Medical Authorization of Statement of Claim

Attach Itemized Bills and

Return This Form To:

**Plumbers & Steamfitters Local 106
Health & Welfare Fund
822 N. Lakeshore Drive
Lake Charles, Louisiana 70601**

To Be Completed By Insured Employee	Is Claim For A Dependent?
Please Print Last Name First Middle	Name Relationship
Home Address	Date of Birth
City -State-Zip Code	If Working, Employers Name & Address
Phone Number	
Date of Birth Sex Social Security Number	
Name of Contractor	Was Accident Involved?
Yes No <input type="checkbox"/> <input type="checkbox"/> IS DISABILITY DUE TO CLAIMANT'S OCCUPATION? <input type="checkbox"/> <input type="checkbox"/> ARE YOU (OR DEPENDENT, IF A DEPENDENT CLAIM) INSURED UNDER ANY OTHER GROUP HOSPITAL AND SURGICAL INSURANCE OR PLAN?	Date of Accident Hour(AM-PM) Where did Accident Occur Describe Accident Fully:
other policy number name of other insurance co. or plan The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, surgeon, practitioner or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A photostat of this authorization shall be as valid as the original.	
_____ EMPLOYEE'S SIGNATURE DATE	

AUTHORIZATION

Important: You must indicate to whom benefits are to be paid.

I authorize payment to:

Myself Dr. _____
(Please Print)

I understand I am financially responsible for any expense not covered by this insurance.

Date _____ Member's Signature _____

NOTICE: THIS PLAN HAS A 1 YEAR (365) DAY FILING PERIOD

Multiplan: For Facility Referral in your area call 1-800-557-6794

Multiplan: For Physician's Referral in your area call 1-800-672-2140

Intracorp: For Pre-Admission Certification call 1-800-222-3711