Railroad Maintenance and Industrial Health and Welfare Fund

Medical Claim Statement

2725 West Monroe Street
Springfield, IL 62704

Employee's Statement

A.	1. Name of Employee	2. Social Security Number	3. Date of Birth	4. Sex ☐ M ☐ F
	5. Home Address	City	State and Zip	
	6. Home Phone	7. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	8. Custody of Children, if any ☐ Yes ☐ No	9. Employer
	10. Name of Spouse	11. Spouse's Social Security Number	12. Spouse's Date of Birth	

B. This Claim is for ☐ Self ☐ Spouse ☐ Unmarried Son ☐ Unmarried Daughter ☐ Other (Provide explanation)

13. If claim is for Dependent: Name of Patient	14. Date of Birth	15. If Claim is for Dependent Child Over Age 18, is the Child a Full Time Student? ☐ Yes ☐ No If yes, provide letter from college Registrar so stating.

C. **If Claim is for Illness** — Briefly describe (for example: heart, pregnancy, etc.)

If Claim is for an Accident	Date/Time of Accident	Where Did it Happen? ☐ Work ☐ Home ☐ Other (Explain)	How Did it Happen?

If an injury, did this injury occur at work? ☐ Yes ☐ No If an illness, was the sickness caused by work? ☐ Yes ☐ No

D. Is Your Spouse Employed? ☐ Yes ☐ No

Name and Address of Spouse's Employer:

Are you or your dependents entitled to benefits for group insurance from ***ANY OTHER*** Employer, Union, Student, Association, Group Plan, or Governmental Program?

☐ Yes ☐ No

Identify Family Member(s) Insured Under ***Other*** Plan	Group Policy Number of ***Other*** Plan

Name(s) and Address of ***Other*** Insurance Company and/or Organization

E.

Release of Information:
I authorize any physician, hospital, insurer or other organization or person having any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by such company to this fund or their duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original. Such information may be used to the extent deemed necessary to determine the validity or amount payable in regard to this claim.

Employee's Signature _____ Date _____

Patient's Signature (Parent if patient is a minor) _____ Date _____

F.

Complete only if you want payment to go directly to provider

Authorization to Pay Benefits:
I hereby authorize payment directly to the provider of service for the enclosed expenses as provided under the Railroad Maintenance and Industrial Health and Welfare Fund Benefit Plan. I understand that I am financially responsible for charges not covered by this authorization.

Employee's Signature _____ Date _____

(This assignment may not be honored if signed by a dependent or person other than the covered Member.)

HOW TO SUBMIT A CLAIM

1. Fill out every section of the claim form completely; if you fail to answer Section D, the form will be returned to you to complete. Payment of your claim(s) will be delayed.

2. Send only original itemized bills (not copies) with your claim.

   Hospital Charges - Attach a fully completed UB-92 Billing Form.

   Other Provider Charges - Attach a HCFA 1500 Billing Form or other fully itemized statement of charges —

   Make sure the bills include the tax identification number, name, address, and telephone number of the hospital or doctor, diagnosis code (ICD-9), procedure code (CPT).

3. If the patient is covered by another group insurance plan which is primary:

   a. the bills must be filed under that plan first;

   b. file a claim with Railroad Maintenance and Industrial Health and Welfare Fund by sending us a copy of the other plan's Explanation of Benefit payment(s) and a copy of the itemized bill(s).

4. Send claims to:

   Railroad Maintenance and Industrial
   Health and Welfare Fund
   2725 West Monroe Street
   Springfield, IL 62704

CLAIMS CANNOT BE PROCESSED FROM BALANCE DUE STATEMENTS