

# MASS. LABORERS' HEALTH & WELFARE FUND

14 NEW ENGLAND EXECUTIVE PARK, SUITE 200 ~~██████████~~ BURLINGTON, MA 01803-~~██████~~<sup>5201</sup>  
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## PROVIDER'S CLAIM FORM

FAILURE TO SUBMIT CLAIM WITHIN 90 DAYS COULD RESULT IN DENIAL OF YOUR CLAIM(S).

ALL QUESTIONS MUST BE ANSWERED FULLY, OR THE FORM WILL BE RETURNED TO YOU.

### -EMPLOYEE'S STATEMENT-

Insured's Name \_\_\_\_\_

Are you a Cobra or Retired Self Pay participant? Yes  No  *If "Yes," please be sure to use the correct Social Security number.*

Individual  Family

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Social Security No. \_\_\_\_\_ Local Union No. \_\_\_\_\_

Insured's Phone No. \_\_\_\_\_

Name of Patient \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_ Birth Date \_\_\_\_\_

Nature of Disability \_\_\_\_\_

Please describe how, when (exact date) and where accident occurred (if additional space is needed, please attach a statement): \_\_\_\_\_

Is this injury or illness in any way related to a condition arising from employment? Yes  No

*If "Yes," claim must be submitted to your employer.*

*If motor vehicle accident, claim must be submitted to your Motor Vehicle Insurance Company.*

Has the patient been totally disabled due to this illness or accident? Yes  No

Date patient became disabled \_\_\_\_\_

Is patient still disabled? Yes  No  If "No," give date returned to work \_\_\_\_\_

If this is a maternity claim, give name and birth date of child \_\_\_\_\_

Is patient covered by other surgical/medical insurance? Yes  No

*If "Yes," name and address of company \_\_\_\_\_*

Give Certificate or Plan Number: \_\_\_\_\_

Is patient covered by Medicare? Yes  No

Medicaid? Yes  No

Medicare/Medicaid Identification No. \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge, and that any false statement could result in a loss of benefits.

Insured's Signature \_\_\_\_\_ Date \_\_\_\_\_

# PROVIDERS CLAIM FORM

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare #)                    MEDICAID <input type="checkbox"/> (Medicaid #)                    TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)                    CHAMPVA <input type="checkbox"/> (Member ID#)                    GROUP HEALTH PLAN <input checked="" type="checkbox"/> (SSN or ID)                    FECA BLK LUNG <input type="checkbox"/> (SSN)                    OTHER <input type="checkbox"/> (ID)				1a. INSURED'S I.D. NUMBER (For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)						
CITY _____ STATE _____		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY _____ STATE _____							
ZIP CODE _____ TELEPHONE (include Area Code) ( ) _____		8. PATIENT STATUS Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE _____ TELEPHONE (include Area Code) ( ) _____							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>			b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____		b. EMPLOYER'S NAME OR SCHOOL NAME						
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>If yes, return to and complete item 9 a-d.</i>						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.							
SIGNED _____ DATE _____				SIGNED _____							
14. DATE OF CURRENT: MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)				22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____							
1. _____ 3. _____ 2. _____ 4. _____				23. PRIOR AUTHORIZATION NUMBER _____							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI		
2									NPI		
3									NPI		
4									NPI		
5									NPI		
6									NPI		
25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO. _____		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE \$ _____	29. AMOUNT PAID \$ _____	30. BALANCE DUE \$ _____			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )					
SIGNED _____ DATE _____				a. _____ b. _____		a. _____ b. _____					