Medicare Wrap-Around Claim Form

For Medicare Eligible Retirees And Medicare Eligible Spouses

PLUMBERS LOCAL UNION No.1 WELFARE FUND

c/o Administrative Services Only, Inc.
303 Merrick Road, Lynbrook, New York 11563-9010
Tel. 516-396-5500 / 800-537-1238

(A) Member Information

(1) Social Security Number ___ (2) Last ___ (3) First ___ (4) Init.

(5) Street ___ (6) City ___ (7) State ___ (8) Zip ___

(9) **Telephone Number** (10) **Date of Birth** (11) **Retired** (12) **Marital Status**

(_____) _____-_____ ___ Month Day Year ☐ Y ☐ N ☐ Single ☐ Married ☐ Divorced ☐ Widowed

(B) Patient Information - Complete only if patient is other than member. See the Welfare Fund SPD for a definition of Eligible Dependent.

Name of Patient (1) First Init. (2) Last	**(3) Date of Birth** Month Date Year	**(4) Relationship to member**	**(5) Social Security Number**
		☐ Spouse	

(C) Accident/Occupation Information – Complete only if claim is a result of an accident or occupational illness/injury.

(1) Is claim due to an accident ☐ YES ☐ No	**(2) Date of accident** Month Date Year	**(3) Is a third party responsible for the injury you sustained?** ☐ YES ☐ No

If auto accident, was patient the ☐ owner, ☐ driver, ☐ passenger, ☐ pedestrian.
If auto accident, was vehicle, ☐ taxi, ☐ bus, ☐ truck, ☐ private passenger, ☐ other
If either "**Yes**" complete the following information. Also, furnish the name of automobile owner, insurance company and policy number, and state in which accident occurred.

(4) Description of accident or occupational illness/injury (How & Where)

(D) HOW TO FILE A CLAIM

1. Complete the claim form and attach all copies of the itemized bills for the expenses incurred and the corresponding explanation of benefits vouchers FROM ALL HEALTH INSURANCE PLANS covering the patient.
2. File a separate claim form for each family individual covered under Medicare and this plan.
3. All claims for benefits must be postmarked no later than 18 months from the date service is rendered.

(E) Employee/Patient Signature and Release – Member must sign all claims. Dependent patient must sign also.

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED.

Member's Signature: _____ **Date:** _____
SIGNED (MEMBER)

Patient Signature: _____ **Date:** _____
SIGNED (PATIENT)

(F) Assignment of Benefits – Complete to assign benefit payment to provider.

I AUTHORIZE PAYMENT OF BENEFITS, OTHER WISE PAYABLE TO ME, FOR SERVICES RENDERED BY THOSE PHYSICIANS OR PROVIDERS AS INDICATED ON THE ENCLOSED BILLS, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY MY BENEFIT PLAN.

Member's Signature: _____ **Date:** _____
SIGNED (MEMBER)