Southern Tier Building Trades Benefit Plan

202 West Fourth Street
Jamestown, NY 14701

Phone: (716) 664-4391
Fax: (716) 483-0677

DOCTOR'S CLAIM FORM

TO BE COMPLETED AND SIGNED BY THE INSURED

INSURED'S NAME			MARITAL STATUS MARRIED ❑ SINGLE ❑
HOME ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP CODE	TELEPHONE NUMBER
INSURED'S SOCIAL SECURITY NUMBER/PIN			PATIENT'S NAME

DESCRIPTION OF ACCIDENT OR SICKNESS

IS THIS INJURY OR SICKNESS DUE TO: AUTOMOBILE ACCIDENT? YES ❑ NO ❑ EMPLOYMENT YES ❑ NO ❑ (Workers Compensation)

HAVE YOU ENTERED A CLAIM UNDER YOUR HOME OWNER'S POLICY? YES ❑ NO ❑

MUST BE COMPLETED ON THE SPOUSE	
NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER	
EMPLOYER'S NAME AND ADDRESS	
NAME OF YOUR INSURANCE COMPANY	

TO BE COMPLETED IF CLAIM ON DEPENDENT CHILD	
NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER
FULL TIME STUDENT YES ❑ NO ❑	EMPLOYED YES ❑ NO ❑
NAME OF SCHOOL ATTENDING	
NAME & ADDRESS OF EMPLOYER	

PAYMENT IS TO BE PAID DIRECTLY TO THE (SELECT ONE) **INSURED ❑** **PROVIDER ❑**

I HEREBY AUTHORIZE ANY PHYSICIAN, DENTIST, HOSPITAL, PHARMACY, INSURANCE COMPANY, EMPLOYER, OR ORGANIZATION TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, DISABILITY, OR BENEFITS PAYABLE FOR THIS CLAIM, TO SOUTHERN TIER BUILDING TRADES BENEFIT PLAN. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE OF INSURED _____ **DATE** _____

ATTENDING PHYSICIAN'S STATEMENT

REPORT OF SERVICES OR ATTACH ITEMIZED BILL

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED	DIAGNOSIS CODE	CPT CODE	CHARGES

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) ABLE TO RETURN TO WORK
FROM THRU DATE

ORIGINAL DATE OF DIAGNOSIS

DOES PATIENT HAVE OTHER HEALTH CARE COVERAGE?
YES ❑ NO ❑ IF "YES" PLEASE IDENTIFY

TOTAL CHARGES	
AMOUNT PAID	
BALANCE DUE	

DATE PHYSICIANS NAME (PRINT) SIGNATURE DEGREE SOCIAL SECURITY NO.

STREET ADDRESS TELEPHONE CITY OR TOWN STATE ZIP CODE

OFFICE USE ONLY

ELIGIBLE

YES ❑ NO ❑

DATE REC'D _____

PROCESSED BY _____

Revised 11/2016