ILWU-PMA COASTWISE INDEMNITY PLAN
Medicare Supplemental Hospital, Medical, and Surgical Benefits Claim Form

(*For Retirees, their Dependents or Survivors Enrolled Under Part A and Part B Medicare*).

1. IDENTIFICATION				
Employee's Name:	Retired ☐ Survivor ☐	Date of Birth:	Local Number:	Registration Number:
If claim is for Spouse, insert SPOUSE'S NAME:				

2. EXPLANATION

Medicare will send you a record of the action taken on your Medicare claim – an **Explanation of Benefits or a Medicare Summary Notice.** The Medicare notice(s) must be submitted with this claim.

TO COMPLETE THIS CLAIM, fill in Part 1, Sign the Authorization (Part 10). If you want payments made directly to the hospital or doctor, complete and sign the *Optional Assignment* (Part 11).

3. Is the patient covered by any other Group Insurance or Health Services Plan? Yes ☐ No ☐

If Yes, what is the Policy Number: _____

Name of Other Plan: _____

Address of Other Plan: _____
(*Street*) (*City & State*) (*Zip Code*)

4. Is patient's condition due to an accident, injury or illness arising out of employment? Yes ☐ No ☐	5. If answer to #4 is yes, have you or the patient filed, or do you intend to file, a claim for benefits under any Federal or State Workers' Compensation Law? Yes ☐ No ☐
6. Is patient's condition due to an accident, injury, or illness caused by some other party? Yes ☐ No ☐	7. If answer to #6 is yes, have your of the patient filed, or do you intend to file, any legal action or claim against the other party? Yes ☐ No ☐
8. Is patient's condition due to an accident? Yes ☐ No ☐	9. If answer to #8 is yes, how, where, and date

10. The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution druggist, insurance company, employer, labor union, or association to release information to ILWU-PMA COASTWISE CLAIMS OFFICE (PO Box 429101, San Francisco, CA 94142) as is required to properly pay all benefits, if any due for this claim.

Employee Signature: _____ Date: _____

Patient (or if Minor, a Parent): _____ Date: _____

PAY TO PROVIDER (OPTIONAL)

11. If you want benefits paid to the provider of care, this section must be signed and dated by the employee:

Employee Signature: _____ Date: _____
(*Insured Employee/Survivor*)

HOW TO FILE YOUR CLAIM:

(1) Member: Fill out and sign Page 1
(2) Provider: Fill out and sign Page 2. In lieu of page 2, submit a fully itemized bill issued by the provider of service
(3) Attach other isurance payment information if applicable
(4) Mail to: ILWU-PMA COASTWISE CLAIMS OFFICE
P.O. Box 429101, San Francisco, CA 94142

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PART 2 – PHYSICIAN'S STATEMENT

1. Patient's Name:

2. Diagnosis and/or Dx Code:
   (a) Is patient's condition due to accident? Yes ☐ No ☐ If yes, give date: _____
   (b) Is patient's condition due to an accident, injury or illness at place of employment? Yes ☐ No ☐
   (c) Is patient's condition due to an accident, injury or illness caused by some other party? Yes ☐ No ☐

3. Date patient first treated for present condition:

4. Is treatment continuing: Yes ☐ No ☐

5. Surgical Procedure(s) performed: Date:
   Date:

6. Confined Hospital Name: From: To:

7. Is patient disabled (unable to perform usual activities)? Yes ☐ No ☐
   If yes, give date: From: _____ To: _____

8. Please attach itemized Bill. In lieu of itemized Bill, itemize Charges below:

DOS	POS	Treatment Diagnosis / Description	Diagnosis Code	CPT Code	YOUR CHARGE TO PATIENT
					$
					$
					$
					$

9. To your knowledge, does patient have other Health Insurance or Health Service Plan Coverage:
   Yes ☐ No ☐ If yes, please identify: _____

Treating Physician(s): _____ M.D.
(Please Print Name)

Federal Tax Number:

Address: _____
(Street, Apt. #)

_____
(City) *(State)* *(Zip Code)*

Telephone Number:

Physician Signature:

Date:

PLEASE RETURN COMPLETED FORM TO: **ILWU-PMA COASTWISE CLAIMS OFFICE**
P.O. Box 429101
San Francisco, CA 94142