DIABETIC DURABLE EQUIPMENT CLAIM FORM

PLEASE READ INSTRUCTIONS BELOW
BEFORE COMPLETING THE CLAIM FORM ON OTHER SIDE.

INSTRUCTIONS

- Employee, prescribing physician, and dispenser of durable equipment must complete this form.

- Attach itemized bill and receipt. **Medicare eligibles** must also attach a copy of the Medicare explanation of benefits denying the payment.

- Mail completed form to: ILWU-PMA Benefit Plans
  1188 Franklin Street – Suite 101
  San Francisco, CA 94109

NOTE: Not more than one Blood Sugar Monitor is provided per family. To verify eligibility for a benefit, contact the Benefit Plans office.

(OVER)

BEFORE COMPLETING THIS FORM, PLEASE SEE OTHER SIDE FOR INSTRUCTIONS.

Part I. - Employee Statement:

1. Employee_____ Local _____ Registration No._____
   (or Survivor) (PLEASE PRINT)
2. Address_____
   (Street)
   _____
   (City) (State) (Zip Code)
3. Patient_____ Relationship to Employee_____
4. Has Employee (or Survivor) filed a prior claim for Diabetic Durable Equipment benefit? ☐ YES ☐ NO
   If answer is yes, date of claim _____/_____/_____
5. Employee's Signature_____ Date_____/_____/_____
   (or Survivor's)
   Telephone Number (optional): (_____)_____

Part II. - Physician's Statement:

I hereby certify that I have prescribed a Blood Sugar Monitor for the purpose of self-administered blood sugar testing for

(Patient)_____.

I further certify this equipment to be medically necessary for monitoring a permanent condition.

Physician (PLEASE PRINT) _____

Address_____
(Street)
_____
(City) (State) (Zip Code)

Signature_____ Date_____/_____/_____

Part III. - Diabetic Durable Equipment Dispenser (Dealer): (Benefit is not assignable.)

Blood Sugar Monitor was purchased on_____/_____/_____ for (Patient)_____

Equipment Description_____ Total Charge $_____

Dispenser_____
(Name)
_____
(Address)

Authorized Signature_____ Date_____/_____/_____

PLEASE PROVIDE ITEMIZED BILL AND RECEIPT.

PLAN OFFICE USE ONLY				
Amt. Payable: $	Examined:	Date:	Certified:	Date:
Circle: Subscriber Code: 1 2 3		Patient Code: 1 2 3		
Copy to Claimant				