# 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 300
  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): (________)______________________________

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***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______/______/______

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***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 | | | | |

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