

# MO-KAN SHEET METAL WORKERS WELFARE FUND

P.O. Box 300019

Phone: 816-531-0334

Kansas City, Missouri 64130-0019

## HEALTH BENEFITS CLAIM FORM

ACTIVE

RETIRED

### EMPLOYEE COMPLETES

1. PATIENT'S NAME		First	Last	PHONE #	2. SEX	3. BIRTHDATE		4. Relationship of patient to employee		1 <input type="checkbox"/> self	2 <input type="checkbox"/> spouse
5. EMPLOYEE'S NAME		First	Last	6. EMPLOYEE'S MOKAN #		Mo.	Day	Yr.	3 <input type="checkbox"/> child	4 <input type="checkbox"/> other	
7. EMPLOYEE'S ADDRESS		Number	Street	<b>AUTHORIZATION TO PAY PHYSICIAN</b> 10. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW (Benefits may already be assigned by policy provision)  SIGNED (Insured or Authorized Person)							
8. City		State	Zip Code								
9. EMPLOYED BY ADDRESS:					LOCAL #						
11. Are you or your family member covered under another group benefits or government plan such as Medicare, an HMO plan, or automobile mandatory no-fault coverage which will also cover any of the medical expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, give name of insurance company, organization, or HMO providing benefits. ATTACH COPIES OF PAYMENT OR DENIAL VOUCHERS PROVIDED BY OTHER PLAN.											
Covered Family Member					Name and Address of Insurance Company						
<input type="checkbox"/> Self <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Other: specify Name and Relationship					Effective Date:						
Policy or Plan No.		Insurance ID Number		Type of Coverage		Is patient employed <input type="checkbox"/> Yes <input type="checkbox"/> No					
				<input type="checkbox"/> Individual <input type="checkbox"/> Family		If yes, give name and address of employer.					
12. IS CONDITION RELATED TO:											
A. PATIENT'S EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO C. ANY OTHER ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO											
13. IF RELATED TO AN ACCIDENT											
DATE _____											
WHERE _____											
HOW _____											
I certify that the above statements are correct and hereby authorize any doctor or organization to provide pertinent records to MO-KAN Sheet Metal Workers Welfare Fund upon request.											
PATIENT'S SIGNATURE						EMPLOYEE'S SIGNATURE					
<b>ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.</b>											

### DOCTOR COMPLETES

14. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. <b>RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE</b>											
1.											
2.											
3.											
4.											
▼											
15.											
A	B	C				D	E		F		
DATE OF SERVICE	PLACE OF SERVICE	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN				DIAGNOSIS CODE (ID: )	CHARGES				
		PROCEDURE CODE (IDENTIFY: )		(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)							
19. I certify that I personally rendered the above services, and that the amounts shown as Fee Charged are the fees that I personally charged the Subscriber and that they are my usual fees for such services.						16. TOTAL CHARGE		17. AMOUNT PAID		18. BALANCE DUE	
DOCTOR'S SIGNATURE						21. TELEPHONE NO.					
						22. SS# OR TAX ID#					
						23. Doctor's printed name & credentials					
20. DOCTOR'S NAME AND ADDRESS (PLEASE PRINT)											

# FILING INSTRUCTIONS

## HEALTH BENEFITS CLAIM FORM

1. Complete the Employee's (upper) portion of the form.
2. Have your physician complete his portion of the form in its entirety.  
Any unanswered questions may cause a delay in the payment of benefits.
3. Send the claim form to the address noted below as soon as possible so that we may start processing claims immediately.

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**Mail to:**

**MO-KAN SHEET METAL WORKERS WELFARE FUND  
P.O. BOX 300019  
Kansas City, Missouri 64130-0019**