ILWU-PMA WELFARE PLAN

CHIROPRACTIC BENEFIT CLAIM FORM

This form is for use by Welfare Plan eligibles enrolled in:

- Kaiser Plans
- Group Health Cooperative of Puget Sound

TO BE COMPLETED BY EMPLOYEE:

Employee Name____________________________ Local________ Reg. No.__________

Employee Social Security Number: _______ - ______ - _______

Address____
Street City State Zip Code

Patient's Name, if not Employee________________ Patient's Date of Birth __________ Relation to Employee__________

1. Is patient covered for chiropractic benefits by any other group insurance or health service plan? ☐ YES ☐ NO

2. Is patient eligible for Medicare? If YES, attach Medicare EOMB. ☐ YES ☐ NO

3. Is patient's condition due to an accident, injury or illness arising out of employment? ☐ YES ☐ NO

4. If answer to No. 3 is YES, has patient filed or does patient intend to file a claim for benefits under any federal or state workers' compensation law? ☐ YES ☐ NO

5. Is patient's condition due to an accident, injury or illness caused by some other party? ☐ YES ☐ NO

6. If answer to No. 5 is YES, has patient filed or does patient intend to file any legal action or claim against the other party? ☐ YES ☐ NO

I authorize release to the Trustees, their agents and their consultants any and all information pertaining to chiropractic care rendered to me or my dependents.

Employee Signature______________________________ Date________________

ASSIGNMENT OF BENEFITS (OPTIONAL):

To be completed and signed by employee if payment of benefit directly to provider of chiropractic care is desired.

☐ I hereby assign my Welfare Plan Chiropractic Benefits to the Chiropractor(s) indicated hereon.

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TO BE COMPLETED BY CHIROPRACTOR:

Patient's Name____

☐ First visit this condition

☐ Repeat visit - date first treated for present condition ______________________

Diagnosis____
and/or
Symptoms ____

To your knowledge, is patient's condition due to an accident, injury or illness arising out of employment? ☐ YES ☐ NO

If YES, please explain____

To your knowledge, is patient's condition due to an accident, illness or condition caused by some other party? ☐ YES ☐ NO

If YES, please explain____

Is treatment continuing? ☐ YES ☐ NO

Please attach itemized bill, or itemize below

Date	Nature of Service	RVS No.	Your Charge to Patient

Attending Chiropractor____
Please print name

Address____
Street City State Zip Code

Federal Tax No.______________________Telephone______________________

Signed______________________Date______________________

MAIL COMPLETED FORM TO:

ILWU-PMA Coastwise Claims Office
Chiropractic Benefit Program
814 Mission Street, Suite 300
San Francisco, CA 94103

MEDICARE ELIGIBLES MUST ATTACH MEDICARE EOMB