MASS. LABORERS' HEALTH & WELFARE FUND

14 NEW ENGLAND EXECUTIVE PARK, SUITE 200 [redacted] BURLINGTON, MA 01803-5201
TEL. (781) 272-1000 FAX (781)238-0703 • WWW.MLBF.ORG

PROVIDER'S CLAIM FORM

FAILURE TO SUBMIT CLAIM WITHIN 90 DAYS COULD RESULT IN DENIAL OF YOUR CLAIM(S).

ALL QUESTIONS MUST BE ANSWERED FULLY, OR THE FORM WILL BE RETURNED TO YOU.

-EMPLOYEE'S STATEMENT-

Insured's Name ______________________________

Are you a Cobra or Retired Self Pay participant? Yes ☐ No ☐ *If "Yes," please be sure to use the correct Social Security number.*

Individual ☐ Family ☐

Street ______________________________

City ______________________ State ____________ Zip ____________

Insured's Social Security No. ______________________ Local Union No. ____________

Insured's Phone No. ______________________________

Name of Patient ______________________ Relationship to Insured: ____________ Birth Date ____________

Nature of Disability ______________________________

Please describe how, when (exact date) and where accident occurred (if additional space is needed, please attach a statement): ______________________________

____

Is this injury or illness in any way related to a condition arising from employment? Yes ☐ No ☐

If "Yes," claim must be submitted to your employer.

If motor vehicle accident, claim must be submitted to your Motor Vehicle Insurance Company.

Has the patient been totally disabled due to this illness or accident? Yes ☐ No ☐

Date patient became disabled ______________________

Is patient still disabled? Yes ☐ No ☐ If "No," give date returned to work ______________________

If this is a maternity claim, give name and birth date of child ______________________________

Is patient covered by other surgical/medical insurance? Yes ☐ No ☐

If "Yes," name and address of company ______________________________

Give Certificate or Plan Number: ______________________________

Is patient covered by Medicare? Yes ☐ No ☐

Medicaid? Yes ☐ No ☐

Medicare/Medicaid Identification No. ______________________________

I certify that the above information is correct to the best of my knowledge, and that any false statement could result in a loss of benefits.

Insured's Signature ______________________________ Date ____________

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PROVIDERS CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☐ TRICARE CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (SSN or ID) ☒ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______________ DATE ______________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______________

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

GCU 25

PLEASE PRINT OR TYPE