NEVADA OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUND

IMPORTANT: To assure payment of Benefits, this form should be FULLY COMPLETED and submitted to the Claim Settlement Office IMMEDIATELY following injury or commencement of treatment.

445 APPLE STREET • P.O. BOX 11337
RENO, NEVADA 89510
TELEPHONE (775)-826-7200

STATEMENT OF MEDICAL CLAIM

CHECK IF YOUR ADDRESS HAS CHANGED SINCE YOUR LAST CLAIM ☐

PART I PATIENT & PLAN MEMBER (EMPLOYEE) INFORMATION

1. Employee's Name (First, Middle, Last Name)	2. Address (Street) (City) (State) (Zip Code)			
3. Name of Company Where You Work and Date of Hire	4. Employee's Social Security Number	5. Union Local No.	6. Employee's Date of Birth	7. Home Phone Number ( ) (Area Code Number)
8. Patient's Name	9. Patient's Employer	10. Patient's Address (Street) (City) (State) (Zip Code)		
11. Patient's Date of Birth	12. Patient's Sex ☐ Male ☐ Female	13. Patient's Relationship To Employee	14. MUST BE ANSWERED IF PATIENT INJURED A. Date of Injury	
15. Was Illness or Injury Connected with Patient's Employment? Yes ☐ No ☐			B. Where did the injury occur? C. How did the injury occur?	

16. Is Any Member of Your Family Covered by any Other Health Insurance, Group Plan, Medicare or Other Government Plan? YES ☐ NO ☐ IF YES, COMPLETE 16a-h	16a. Effective Date		
16b. Please provide Name, Address, and Phone Number of OTHER Plan or Group.		16c. Are Your Dependents Covered? YES ☐ NO ☐	16d. PLAN TYPE Active ☐ Retiree ☐
16e. Name of Employer or Organization Providing Other Coverage:	16f. Name of Primary Person Covered Under Other Plan	16g. Identifying No./SS No. of Primary Person Covered Under Other Plan	16h. Primary Person's Date of Birth

17. **RELEASE OF INFORMATION:** I authorize any medical information relating to this Claim to be disclosed to and acquired by the Administrator of this Plan and such agents of the Administrator as are necessary to process this Claim. Such information may be disclosed by a Health Care Provider or other Plan Administrator, and will be used for the purpose of processing this Claim. This authorization shall remain valid until the Claim is paid, provided, such information shall be retained by the Administrator if required by law. Any person who knowingly files a statement of Claim containing any any false or misleading information is subject to **Criminal and Civil Penalties in Certain States.** Upon request, the patient shall be furnished with a copy of this authorization.

X _____ Patient's Signature (Parent or Guardian's Signature, if Patient is a minor).

18a. **PAYMENT AUTHORIZATION:** **PAY MEMBER** ☐ **PAY PROVIDER** ☐
I authorize the Administrator, in his sole discretion, to pay directly to the below named physician or any other supplier of services, any benefits otherwise payable to me, but not to exceed any of the charges by the by the physician or other supplier of services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____ EMPLOYEE'S SIGNATURE _____ DATE

18b. I hereby certify that the foregoing statements including any accompanying statements are to the best of my knowledge and belief true and correct.

X _____ EMPLOYEE'S SIGNATURE _____ DATE

PART II PHYSICIAN OR SUPPLIER INFORMATION

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER—OR YOU MAY ATTACH AN ITEMIZED BILL INCLUDING DIAGNOSIS

19. DATE OF: ☐ ILLNESS (FIRST SYMPTOM) OR ☐ INJURY (ACCIDENT) OR ☐ PREGNANCY (LMP)	20. DATE FIRST CONSULTED YOU FOR THIS CONDITION	21. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐	WORK RELATED? YES ☐ NO ☐
22. DATE PATIENT ABLE TO RETURN TO WORK	23. DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH	
24. NAME OF REFERRING PHYSICIAN		25. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
26. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)		27. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES:	

28. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

29. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F

30. SIGNATURE OF PHYSICIAN OR SUPPLIER		31. TOTAL CHARGE	32. AMOUNT PAID	33. BALANCE DUE
SIGNED DATE	34. YOUR SOCIAL SECURITY NO.	35. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
36. YOUR PATIENT'S ACCOUNT NO.	37. YOUR EMPLOYER I.D. NO.	LICENSE NO.		

*PLACE OF SERVICE CODES
1—(IH) —INPATIENT HOSPITAL
2—(OH)—OUTPATIENT HOSPITAL
3—(O) —DOCTOR'S OFFICE
4—(H)—PATIENT'S HOME
5— DAY CARE FACILITY (PSY)
6— NIGHT CARE FACILITY (PSY)
7—(NH) —NURSING HOME
8—(SNF)—SKILLED NURSING FACILITY
9— AMBULANCE
0—(OL)—OTHER LOCATIONS
A—(IL) —INDEPENDENT LABORATORY
B— OTHER MEDICAL/SURGICAL FACILITY