Medical and Vision Claim Form

SPOKANE FIRE FIGHTERS BENEFIT TRUST

Instructions:
Complete this form, attach all itemized bills, send to the plan administrator at the address printed on the backside of this form, & keep a copy for your records.

WPAS Claims Office 1-888-563-0665
P.O. Box 34564
Seattle, WA 98124-1564

PART I - TYPE OF CLAIM: Check type(s): □ Medical □ Vision

PART II - EMPLOYEE DATA:

Employee Name:_____ Member ID# _____
(First Name) *(Last Name)*

Date of Birth: _____/_____/_____

Mailing Address:_____
(Street) *(City)* *(State)* *(Zip)*

PART III - PATIENT DATA: Claim is for: □ Employee □ Spouse □ Dependent Child

Patient Name:_____ Birth Date: _____/_____/_____
(First Name) *(Last Name)*

If claim is for dependent child, indicate relationship: □ Child □ Step Child □Legal Guardianship □ Other_____
If age 26 or older, does child have a developmental disability, physical handicap, or live at home? □ Yes □ No
If yes, contact the Claims Office for instructions.

PART IV - OTHER INSURANCE INFORMATION:

Does patient have other health insurance coverage: □ Yes □ No If yes, check type: □ Medical □ Dental □ Vision

Subscriber Name: _____ Subscriber SS#: _____

Insurance Company/
Plan Administrator's Name _____ Phone Number: _____

Policy/Plan Number: _____

Mailing Address: _____
(Street) *(City)* *(State)* *(Zip)*

PART V - CLAIM INFORMATION (complete only applicable information):

Are expenses related to an accident? □ Yes □ No If yes, indicate date of accident _____/_____/_____ and type of accident:

□ Automobile □ Home/Recreational

□ Employment-Related: Name, address & telephone of employer: _____

□ Other_____

Briefly describe accident: _____

_____

Note: If claim is related to an accident, you will receive an "accident questionnaire". Respond promptly to expedite claim processing.

PART VI - AUTHORIZATION TO PROCESS CLAIM:

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Welfare & Pension Administration Service, Inc. (WPAS) and the plan holder, or their representatives, any information regarding my and/or my dependent's health history, symptoms, treatment, examination results or diagnosis. This authorization shall be considered valid for the duration of the claim. ***Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.***

I AUTHORIZE BENEFIT PAYMENT TO THE HEALTH PROVIDER FOR THE SERVICES AND/OR SUPPLIES DESCRIBED ON THIS CLAIM FORM. □ Yes □ No

_____ _____/_____/_____
Eligible Participant's Signature Date

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name	Age
Diagnosis and concurrent conditions	
Is condition due to injury or sickness arising out of patient's out of patient's employment? Yes □ No □	
Complete report of services or attach an itemized bill if a previous form has been submitted, you need to show only dates and services since last report: Date of procedures: _____ Serviced Rendered Code _____ Description of service procedures:	CHARGES
Total Charges	$
Amount Paid	$
Balance Due	$

This area must be completed by the attending physician if applying for weekly disability benefits

Date Symptoms first appeared or accident happened:	Date patient first seen for this condition:
Has patient ever had same or similar condition? Yes □ No □ If "Yes", When and describe:	Is patient still under your care for this condition? Yes □ No □
Patient was continuously totally disabled (unable to work) provide dates From: Through:	Last day worked:
If still disabled, date patient should be able to return to work:	Date employee returned to work:
Does patient have other health coverage? Yes □ No □ If "Yes", Please identify	
Date Physician Name (PRINT) Signature Degree Telephone	
Street Address City-State-Zip Code	Individual Practitioners TIN OR SS#

PROCEDURE FOR FILING A CLAIM

1. Complete all applicable sections of the "Employee Statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim.
2. Attach an itemized bill for all charges related to this claim.
3. Complete a separate form for each patient.
4. Mail completed member paid medical and vison claim form and itemized bills to:
   Spokane Fire Fighters Benefit Trust
   P.O. Box 34564
   Seattle, WA 98124-1564
5. Providers submit medical and vision claims to: Your local Blue Cross and/or Blue Shield Plan
6. For dental claims submission: Contact Delta Dental www.deltadental.com or (800) 554-1907

To ensure prompt payment submit only itemized bills. An itemized bill is the actual bill from the provider showing: a) date of service; b) diagnosis; c) procedure done and d) cost of each procedure. A "balance due" or non-itemized bill is NOT acceptable. If you have other Group Insurance or Medicare as your primary coverage you need to submit the itemized bill AND a copy of the matching Medicare or other insurance payment explanation.