

For Eligibility & Benefits call 1800-533-4742

Electrical Workers
H&W Trust Fund Local 234

Medical Claim Form

Part I Employee completes

Send Claims to:
Pacific Health Alliance
Attn: Electrical Workers
1350 Old Bayshore Hwy #560
Burlingame, CA 94010

EMPLOYEE'S NAME - Last		First		SOCIAL SECURITY NO.		HOME PHONE	
ADDRESS - Street & No.				City		State	
DATE OF BIRTH		BUSINESS PHONE		PLAN NO. (as shown on your card)			

PATIENT NAME		RELATIONSHIP () Self () Child () Spouse () Step/Foster Child		PATIENT'S BIRTHDATE	
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ACCIDENT? () Yes () No If "yes" explain and give date of accident		WORK INCURRED? () Yes () No If "yes" explain	
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OTHER INSURANCE: PHONE NUMBER:		Is Patient covered by another Group Plan or Insurance? () Yes () No	
NAME OF MEMBER, OTHER PLAN SOCIAL SECURITY NO.		NAME OF OTHER PLAN OR INSURANCE	
ADDRESS - Street & No.		City	
ADDRESS - Street & No.		City	
EMPLOYER		ADDRESS - Street & No.	
ADDRESS - Street & No.		City	

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to the provider of services by HIA, Inc. of any benefits otherwise payable to me but not to exceed the charges shown below. I understand I am financially responsible for any charges not covered by this authorization.		EMPLOYEE'S SIGNATURE (Employee must sign personally)		DATE SIGNED	
PATIENT'S AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION: I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician or Surgeon, other supplier of service to release any information requested by the Claims Administrator, HIA, necessary to process this claim. A photocopy of this authorization shall be as valid as the original.					
PATIENT'S SIGNATURE (Employee must sign personally, if patient is a minor, the authorization may be signed by the minor's parent, conservator or guardian)		DATE SIGNED			

PART 2 - PHYSICIAN'S STATEMENT
(PLEASE TYPE OR PRINT OR ATTACH AN ITEMIZED BILLING)

DIAGNOSIS (Name of illness or injury and complications, if any)		Does Patient have other Insurance? () Yes () No	
NAME OF HOSPITAL		SERVICES ARE THE RESULT OF	
ADMISSION DATE		DISCHARGE DATE	
CONTINUOUSLY DISABLED		UNABLE TO WORK FROM TO	
() Sickness () Pregnancy		() Accident Examination	
() Work Injury () Physical			

DATE	HOME	OFFICE	HOSPITAL	RVS NUMBER OR DESCRIPTION OF SERVICE	CHARGE	OFFICE USE ONLY
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PHYSICIAN'S NAME		Tax ID #		PHONE	
ADDRESS - Street & No		City		State	
Zip Code					