

# IBEW LOCAL 234 HEALTH AND WELFARE PLAN

**Send Claims to:**

Pacific Health Alliance  
1350 Old Bayshore Highway #560  
Burlingame, CA 94010

## MEDICAL CLAIM FORM

**For Eligibility &  
benefits please call**  
877-885-3753 or  
408-588-3753

### PART 1 EMPLOYEE COMPLETES

#### TO BE COMPLETED BY EMPLOYEE

Patient's Name (Last Name First)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Employee's Complete Name and Address Name:		Employee's Soc. Sec. No.	Patient's Birthdate
Street No.:			Mo.      Da.      Yr.
City, State, Zip Code:		Relationship to Employee	
Home Phone:		Business Phone:	
Name of Employer		Address:	Plan No. (as shown on your card)
This Condition was caused by: <input type="checkbox"/> Illness <input type="checkbox"/> Injury		If Injury, Date sustained, How and Where sustained:	
Is Condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OTHER INSURANCE			
Other Insurance Phone Number:		Is Patient covered by another Group Plan or Insurance? ( ) Yes ( ) No	
Name of Members Other Plan or Insurance		Social Security No.	Group or I.D. No.
Address-Street & No.		City	State      Zip Code
Employer			
Address-Street & No.		City	State      Zip Code
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.			
Employees Signature (Employee must sign personally)			Date
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

### 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	Services are a result of
	Name of Hospital	( ) Work injury ( ) Physical Exam
	Admission Date      Discharge Date	( ) Accident ( ) Pregnancy
	Continuously Disabled      Unable to work From/To	( ) Sickness

DATE	HOME	OFFICE	HOSPITAL	RVS #OR DESCRIPTION OF SERVICE	CHARGE	OFFICE USE ONLY
Physicians Name			Tax ID #	Phone		
Address- Street & No.		City		State	Zip Code	