Medical / Dental / Time Loss Claim Form

ALASKA LABORERS HEALTH AND SECURITY FUND

A Self-Funded Health Plan

P. O. Box 34567, Seattle, WA 98124-1567

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

For Toll-Free Assistance Nationwide Call:
Welfare & Pension Administration Service
Claims Office 1-855-815-2323

PART I - TYPE(S) OF CLAIM: Check type(s): ☐ Medical ☐ Dental ☐ Time Loss

PART II - EMPLOYEE DATA:

Employee Name:_____ Social Security No.:_____
(First Name) (Last Name)

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 child is age 22 or older, is child a full-time student? ☐Yes ☐ No
If yes, current semester enrollment form must be on file
If no, does child have a developmental disability, physical handicap, or live at home? ☐ Yes ☐ No

If claim is for dependent child, indicate relationship:
☐ Child ☐ Step Child ☐ Legal Guardianship
☐ Other_____

PART IV - OTHER INSURANCE INFORMATION:

Does patient have other health insurance coverage: ☐ Yes ☐ No If yes, please complete the following for each policy/plan:
Insurance company/plan administrator's name, address, telephone #, policy/plan #, and types of coverage:

1._____ ☐ Medical ☐ Dental

2._____ ☐ Medical ☐ Dental

Is spouse employed? ☐ Yes ☐ No If yes, please write name, address and telephone number of employer and/or union local:

_____

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

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

☐ Home/Recreational ☐ 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 planholder, 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 EMPLOYMENT? YES ☐ NO ☐ PREGNANCY? YES ☐ NO ☐ IF "YES", APPROXIMATE DATE PREGNANCY COMMENCED.			
COMPLETE REPORT OF SERVICES OR ATTACH AN ITEMIZED BILL IF A PREVIOUS FORM HAS BEEN SUBMITTED, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT DATE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	C.P.T. PROCEDURES CODE	CHARGES
		TOTAL CHARGES	$
		AMOUNT PAID	$
		BALANCE DUE	$

THIS AREA MUST BE COMPLETED BY THE ATTENDING PHYSICIAN IF APPLYING FOR TIME LOSS/DISABILITY BENEFITS

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST CONSULTED FOR THIS CONDITION
PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐ IF "YES", WHEN AND DESCRIBE:	PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) GIVE DATES FROM THRU	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'S 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. **If claim is for disability, a doctor MUST complete the "Attending Physician's Statement" shown above.**
3. Complete a separate form for each patient.
4. **SUBMIT COMPLETED FORM AND ITEMIZED BILLS BY MAIL, FAX, OR EMAIL TO:**

***MAIL*: ALASKA LABORERS TRUST**
P.O. BOX 34567
SEATTLE, WA 98124-1567

***FAX*:** (206) 441-9110

***EMAIL*:** claimstatus@wpas-inc.com

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.