# 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 ☐<br>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<br>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?<br>YES ☐ NO ☐ IF "YES", WHEN AND DESCRIBE: | PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?<br>YES ☐ NO ☐ |
| PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) GIVE DATES<br>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.