



OPERATING ENGINEERS LOCAL No. 99 BENEFIT FUND

If seen by an BlueCross PPO Provider:

If seen by a Non-PPO Provider:

Send all claims to: CAREFIRST BC/BS PPO P.O. Box 9784 Towson, MD 21284 INFO. 1-800-235-5160

Send all claims to: 5901 Harford Road - Suite C Baltimore, MD 21214 Info: 410-254-9595 / 1-800-367-7848



STATEMENT OF CLAIM TO BE SUBMITTED WITHIN 1 YEAR OF SERVICE TO BE COMPLETED BY MEMBER.

- 1. Print your name S.S. # A52
2. If claim is for dependent -- state name of dependent Relationship of dep. age of dep.
3. Home Address
4. Nature of Disability
5. If disability due to accident or injury, describe HOW, WHEN and WHERE it happened

The above answers are true and complete to the best of my knowledge and belief.

Signature Date

TO BE COMPLETED BY ATTENDING PHYSICIAN.

- 1. Patient's name age
2. Date first examined Where
3. Diagnosis ICD 9 Code

Table with 7 columns: Date of Service, CPT Code, Place of Service*, Description, Unit / Days, Charge, Office Use. Includes a TOTAL row at the bottom.

Provider Tax I.D. No. Physician Signature Date
Provider Name (Please Print) Address Telephone

To be completed and signed by the member if direct payment by Fund to surgeon or physician is desired. (This assignment may not be honored if signed by a dependent or person other than the claimant.) Proof of payment is required if member is to be reimbursed for \$100 or more.

Date

I hereby authorize the Operating Engineers Local No. 99 Benefit Fund to pay directly to Dr. (Print Name of Doctor) the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Group Policy and Certificate to the extent of his interest as established herein.

Claimant's Assignment (Read before signing)

(Signature of Insured Member)