LOCAL 211 INTERNATIONAL UNION OF OPERATING ENGINEERS

ALLIED BUILDING INSPECTORS

225 BROADWAY, 43RD FLOOR, NEW YORK, NY 10007

WELFARE FUND
CHIROPRACTOR/PODIATRY BENEFIT CLAIM

Phone: (212) 233-2690
Fax: (212) 962-2523
email: info@iuoe211.com

TO BE COMPLETED BY MEMBER

Last Name _____ First Name _____ M.I. _____

Address _____
Street Address Apt. No. City State Zip Code

Cell Phone _____ Personal Email _____ SSN _____

Job Title _____ Agency/Dept. _____

Are you or your dependent entitled to benefits under other insurance coverage? ☐ Yes ☐ No

If the answer is "YES" please check: ☐ GHI ☐ Medicare ☐ Other

Member Signature _____ Date _____

TO BE COMPLETED BY CHIROPRACTOR OR PODIATRIST

1. Patient's Name _____ Age_____ Relation to Member _____

2. Diagnosis/Nature of sickness or injury _____

_____

3. Did this sickness or injury arise out of patients employment? ☐ Yes ☐ No

If "YES", explain_____

DATE	DESCRIPTION OF SERVCIES	FEE	PAID BY MEMBER*

**** Actual out of pocket paid by member (ie. GHI or Medicare Co-Pay)***

4. Have you completed any other Insurance forms for this patient? ☐ Yes ☐ No

If "YES", indicate name of provided (GHI, Medicare, Etc.) _____

Name_____ License No_____

Address _____ Tax ID No_____

City _____ State _____ Zip _____

Date_____ Signature_____

(Check One) ☐ CHIROPRACTOR ☐ PODIATRY

This claim form must be returned to fund office within 180 Days of first visit.

Claim will not be processed unless signed by member and Chiropractor or Podiatrist.