IUPAT LOCAL 177 WELFARE TRUST FUND
Supplementary Health Claim Form

Attach the original receipts for all expenses. Receipts will not be returned, as a copy of the Explanation of Benefits is sent to you and copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans.

Your claim will be returned to you if the claim form is incomplete.

Member Information Section

Plan Sponsor / Employer Name						
Group Number	Certificate Number	Gender			Language Preference	
59315		☐ Male	☐ Female	☐ Other	☐ English	☐ French
Last Name	First Name	Date of Birth				
		Month Day Year				
Mailing Address	City	Province	Postal Code			
Phone Number	Cell Phone	Email Address				

Patient Information Section

Does the patient have any other coverage which would pay a benefit for this claim?	☐ Yes	☐ No
If yes, please indicate the date of birth of the insured: Month Day Year		
If yes, attach photocopies of vision receipts and the co-insurance statement.		
Is the treatment required as the result of an accident?	☐ Yes	☐ No
If yes, indicate the accident date, location, and details on how the accident occurred.		
Is the treatment required as the result of a work-related injury?	☐ Yes	☐ No
If yes, is a claim being made for Worker's Compensation Benefits?	☐ Yes	☐ No

Claim Details Section

Patient Name (Last, First)	Relationship to Member	Date of Birth	Type of Service	Date of Service	Total Charges
		MM DD YYYY		MM DD YYYY	
		MM DD YYYY		MM DD YYYY	
		MM DD YYYY		MM DD YYYY	
		MM DD YYYY		MM DD YYYY	

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Payment Assignment Section
** To Assign Payment Directly to Supplier **

I hereby assign my benefits payable from this claim to _____ and authorize payment directly to the supplier.
Name of Supplier

_____ Month / Day / Year

Signature of Member **Date Signed**

Authorization—Signature Required Below

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Ellement Consulting Group to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan. I certify that the information given is true, correct, and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount.

_____ Month / Day / Year

Signature of Member **Date Signed**

Signature Required on Page 2

IUPAT LOCAL 177 WELFARE TRUST FUND
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Physician's Recommendation
(For Major Medical Supplies)

1. Patient's Name _____

2. Recommended medical item(s) – describe in detail including specifications when available

3. Indicate activities requiring this item _____

4. Diagnosis of medical condition with specific reason for recommendation of medical item(s)

5. Condition of patient: ☐ Acute ☐ Chronic ☐ Palliative

6. a) Date patient first consulted you for this condition Month Day Year

   b) Are you actively treating this patient for this condition Yes No If no, please provide comments

7. To the best of your knowledge, what is the duration for use of the recommended item(s) _____

8. For hospital beds only, please indicate the hours or percentage of time in bed _____

9. For replacement of a prosthesis or other equipment, please provide:

   a) Date of prior replacement Month Day Year

   b) Reason for replacement _____

10. Is the device(s) and/or medical equipment required:

    a) As a result of a work-related injury? ☐ Yes ☐ No
    b) As a result of a motor vehicle accident? ☐ Yes ☐ No
    c) For sports purpose only? ☐ Yes ☐ No

11. Has an application been made for government funding? ☐ Yes ☐ No If no, please give reason

Physician's Name _____ Physician's Signature _____

General Practitioner ☐
Specialist ☐

Date Signed _____ Phone Number _____

THE PATIENT IS RESPONSIBLE FOR SECURING THIS FORM AND ANY CHARGES MADE FOR ITS COMPLETION.

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_____ Month / Day / Year _____

Signature of Member **Date Signed**