**INDIANA LABORERS WELFARE FUND**
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# Medical Claim Form

**A separate claim form is required for each patient and provider. Make sure every section is completed and all required documents are attached.**

| PATIENT INFORMATION: | | | |
|---|---|---|---|
| Identification Number: | | Group Number: | |
| Last Name: | | First Name: | M. I. |
| Address: | | City/State/Zip Code | |
| Does the patient have other insurance? Yes ☐ No ☐ | Relationship to Participant: | Date of Birth: | Sex: M ☐ F ☐ |
| Name of other insurance company: | Group Number: | Policy Number: | |

| MEDICAL INFORMATION: | | |
|---|---|---|
| **Health Care Services:** This section is designated for the reporting of any covered health care service that has not previously been submitted to UnitedHealthcare by the provider of service. An itemized bill must be attached. | | |
| Where was the service rendered? | | |
| Is this service a result of an accident? | ☐ Yes | ☐ No |
| Was this service for a condition or injury that is job related? | ☐ Yes | ☐ No |
| Have you filed for Workers' Compensation? | ☐ Yes | ☐ No |
| When did the injury or accident occur? | Date: | |

| DATE OF SERVICE | DIAGNOSIS CODE | PROCEDURE CODE | TAX ID | AMOUNT |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | **TOTAL** | $ |

## ALL BILLS MUST BE ITEMIZED

Each itemized bill must include:

- Name and address of provider
- Name of patient
- Service provided
- Date of service
- Amount charged for each service
- Diagnosis code
- Procedure code
- Tax ID

**I hereby certify that all of the above statements are true, complete and accurate and authorize the release of medical information to process this claim.**

**Signature:** _____ **Printed Name:** _____ **Date:** _____