

PUGET SOUND ELECTRICAL WORKERS HEALTH AND WELFARE TRUST

EMPLOYEE STATEMENT

<input type="checkbox"/> Check here if your address is new.						PART 1 – EMPLOYEE INFORMATION											
EMPLOYEE NAME – First			Initial		Last		<input type="checkbox"/> M <input type="checkbox"/> F		EMPLOYEE WPAS ID # OR SOCIAL SECURITY NO.			EMPLOYEE BIRTHDATE Mo. Day Year					
HOME ADDRESS		STREET			CITY			STATE		ZIP		PHONE					
EMPLOYED BY										LOCAL NO.							
PATIENT'S NAME – First			Initial		Last		<input type="checkbox"/> M <input type="checkbox"/> F		PATIENT ID # OR SOCIAL SECURITY NO.			PATIENT BIRTHDATE Mo. Day Year			RELATION TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
EMPLOYEE MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGAL SEP. <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVOCED		IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> ADOPTED CHILD <input type="checkbox"/> FOSTER CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> GUARDIANSHIP <input type="checkbox"/> OTHER (EXPLAIN) _____						IF DEPENDENT CHILD IS AGE 19 OR OLDER, IS CHILD ENROLLED AS A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF SCHOOL _____ IF "NO", DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? <input type="checkbox"/> YES <input type="checkbox"/> NO									
NAME OF SPOUSE (if not patient listed above)								SPOUSE BIRTHDATE Mo. Day Year			SPOUSE ID # OR SOCIAL SECURITY NO.						
IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME & ADDRESS SPOUSE'S EMPLOYER															

PART 2 – INSURANCE INFORMATION

ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? YES NO
 IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER NAME _____ ADDRESS _____
 NAME OF SUBSCRIBER _____ SUBSCRIBER ID # OR SOCIAL SECURITY NO. _____
 OTHER GROUP PLAN COVERS: PATIENT SPOUSE CHILDREN OTHER GROUP PLAN POLICY OR I.D. NO. _____
 OTHER GROUP PLAN INCLUDES: MEDICAL DENTAL VISION
 ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? YES NO IF YES { NAME OF PERSON COVERED _____
 MEDICARE EFFECTIVE DATE _____

PART 3 – ACCIDENT/INJURY INFORMATION

WAS VISION CARE REQUIRED BECAUSE OF AN INJURY? YES NO DID ACCIDENT OCCUR WHILE AT WORK? YES NO
 DATE INJURED _____ DESCRIBE HOW INJURY OCCURRED: _____
 HAS CLAIM BEEN FILED WITH LABOR AND INDUSTRIES? YES NO IF "YES", GIVE CLAIM NUMBER _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his or her services but not to exceed the reasonable and customary charge for those services. Do not sign if bills have been paid.

I hereby certify that the foregoing statements, including any accompanying statements, are true and correct and complete to the best of my knowledge, and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge. A photocopy of this authorization is as valid as the original.

Employee Signature _____ Date _____ Patient Signature (if not minor child) _____
 Employee Signature _____ Date _____

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 relating to this claim **or have Physician complete reverse side of this form.**
3. Complete a separate form for each patient.
4. **Mail completed form and itemized bill to:**

P.S.E.W. TRUST
P.O. BOX 34970
SEATTLE, WASHINGTON 98124-1687
 PHONE: (206) 441-4667 OR (866) 314-4239

To insure 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 insurance or Medicare payment explanation.

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

1. HAS PATIENT WORN EYEGLASSES BEFORE THIS EXAMINATION? _____ TYPE _____
IF "YES", STATE REASON FOR REPLACEMENT _____

2. IF YOU PRESCRIBED EYEGLASSES, CHECK TYPE: SINGLE VISION BIFOCAL TRIFOCAL OTHER (DESCRIBE) _____

3. HAS CATARACT SURGERY BEEN PERFORMED? YES _____ NO _____ DATE _____

4. CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL EYEGLASSES? _____

5. ARE EXISTING FRAMES BEING USED FOR THE NEW EYEGLASSES? YES NO IF "NO", WHY NOT? _____

PROCEDURE CODES	DATES OF SERVICE	AMOUNT OF CHARGE	
ATTACH ITEMIZED BILLS	SUBTOTAL		
	TAX		
	TOTAL		

COMMENTS:

DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES NO IF "YES", PLEASE IDENTIFY _____

SIGNATURE BY DOCTOR CERTIFIES THAT ALL SERVICES LISTED ABOVE HAVE BEEN COMPLETED

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
STREET ADDRESS		CITY	STATE	ZIP
INDIVIDUAL PRACTITIONERS TIN OR SS NO.		NPI		

SEE OTHER SIDE FOR INSTRUCTIONS

BENEFIT, CLAIMS PAYMENT AND ELIGIBILITY INFORMATION
MAY BE OBTAINED FROM:
WELFARE & PENSION ADMINISTRATION SERVICE, INC.
PHONE: (206) 441-4667 or (866) 314-4239

Sdg opeiui#8
S:\SHARED SEC\FORMS\Claims\F33-02 - Form - Vision - 2010.docx