1. Complete This Form
2. Attach All Bills
3. Mail To →

NEW MEXICO PIPE TRADES HEALTH & WELFARE FUND
ADMINISTRATIVE OFFICE
6301 Indian School Road, Ste. 660, Albuquerque, NM 87110
TELEPHONE (505) 881-3141

PARTICIPANT'S STATEMENT

CLAIM FORM

NAME OF EMPLOYEE	SOCIAL SECURITY NO.	DATE OF BIRTH
STREET NUMBER — CITY AND STATE		PHONE NO.
NAME OF DEPENDENT (IF PATIENT) — RELATIONSHIP TO EMPLOYEE		DATE OF BIRTH
DATE ACCIDENT OR SICKNESS BEGAN — DID ACCIDENT OCCUR WHILE AT WORK? YES ☐ NO ☐	ATTENDING PHYSICIAN'S NAME	

NATURE OF SICKNESS, INJURY, DIAGNOSIS OR MEDICAL CALL
IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN

Are you or your dependent insured under any other group insurance or government plan which will also pay for any of the medical expenses of this claim?
If yes, give name and address, and policy number, or insurance company providing benefits.
NAME AND ADDRESS — YES ☐ NO ☐

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN. I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below, but not to exceed the reasonable and customary charge for those services.

SIGNED (INSURED PERSON) — DATE

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish the New Mexico Pipe Trades Health and Welfare Fund with full information regarding treatment rendered (including copies of their records.) In order for you to coordinate benefits, I/we also authorize any Union, Trust Fund Employer, Insurance Carrier or Service Organization to furnish the New Mexico Pipe Trades A Health and Welfare Fund with information regarding benefits to which I/we also may be entitled. (If claim for spouse, spouse also must sign.)

EMPLOYEE'S SIGNATURE — SPOUSE'S SIGNATURE

ADDRESS — CITY — STATE — ZIP — DATE SIGNED

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME — AGE

DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA* USED, GIVE NAME)

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

PREGNANCY? ☐ YES ☐ NO

IF YES, APPROXIMATE DATE PREGNANCY COMMENCED

REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES +	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE - IF USED (IF CODE OTHER THAN SERVICES CPT** USED) GIVE NAME?	CHARGES

TOTAL CHARGES $ _____
AMOUNT PAID $ _____
BALANCE DUE $ _____

+ DO - Doctor's Office
H - Patient's Home
IH - Inpatient Hospital
OH - Outpatient Hospital
NH - Nursing Home
OL - Other Locations

•ICDA -- International Classification of Diseases
••CPT -- Current Procedural Terminology (current edition)

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO IF "YES" WHEN AND DESCRIBE:	☐ NO PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION ☐ YES ☐ NO
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM THRU	LAST DAY WORKED / DATE
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	DATE EMPLOYEE RETURNED TO WORK

DOES PATIENT HAVE OTHER HEALTH COVERAGE? ☐ YES ☐ NO IF "YES" PLEASE IDENTIFY:

DATE — PHYSICIAN'S NAME (PRINT) — SIGNATURE — DEGREE — TELEPHONE

STREET ADDRESS — CITY – STATE – ZIP CODE

INDIVIDUAL PRACTITIONER'S S.S.# _____
ALL OTHERS – EMPLOYER I.D.# _____

MUST BE FURNISHED UNDER AUTHORITY OF LAW