## MEDICAL CLAIM (Non-Occupational Sickness or Accident)

Send completed form with itemized bills within 90 days to:

Teamsters Benefit Trust (TBT) • P.O. Box 5820 • Fremont, CA 94537-5820 • (510) 796-4676 • (800) 533-0119

	PART I — EMPLOYEE MUS  nployee's Name (Last, First, Middle Initial) Please Print		Birth Date (Month-Day-Y				curity Number		Local Union Number		
Spouse's Name (Last, First, Middle I	Birth D	Date (Month-Day-	Year) Social Security Number			nber	E (	Home Phone			
Home Address Please Print				City		State		Zip	Employee's Employer		
Patient's Name (Last, First, Middle Initial) Please Print	Social Security Num	ber Birth Date (Month-Day-Year)		If Dependent, Relationship?		Is Disability Due to W Incurred Condition? YES NO			If Ful	  -Time Student, School Name	
If Disability is Due to Accident	, Describe How, When	and Wh	nere?								
Is Patient Covered YES  NO  If A					_	an or (	Govern	ment	Plar	n?	
Name and Address of Patient's Other Plan or Group							Grou	Group No. or Policy No.			
Name of Employer or Organization Providing Other Coverage			e	Name of Primary Person Covered Under Other Plan				Identifying No./Social Security No. of Primary Person Covered Under Other Plan			
Check if this is y	our first claim	ı. 📮	☐ Check	if you	have n	noved s	since y	our l	ast c	laim.	
☐ Check if this is y  Employee Assignn			☐ Check	if you	have n	noved s	since y	our l	ast c	laim.	
<b>Employee Assignm</b> I hereby authorize the ac	nent of Benefi	i <b>ts</b>	e below na	med phys	sician any	y payme	nts other	wise o	lue ar	nd payable	
<b>Employee Assignm</b> I hereby authorize the ac	nent of Benefi	its y to the or one	e below na	med phys ble depen	sician any	y payme	nts other	wise o	lue ar	nd payable	
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NOTE TO THE DOCTOR OR PROVIDER:

This Authorization must be given to the patient or sent to the designated address at the top of this form. If you wish, you may copy the Authorization.

PART III — F	PHYSICIAN	MUS	ST CO	MPLETE	(Please t	ype or p	rint)				
Name of Patient (Last, Fin	rst, Middle Initial)										
Physician's Diagnosis (I	Describe Complication	s if Any)	ı								
Is Disability Due to Wor	rk Incurred Condition	P	Is Disability Due to Pregnancy? YES \( \bigcup \) NO \( \bigcup \)			Is Disability YES	Is Disability Due to Alcoholism or Narcotic Addiction?  YES  NO				
			sion Date	Dismissal Da (Month-Day-Year			Have Other Health  e P YES NO  No  Name of Health Plan				
Patient L	Disabled From	)		(Month-Day-Year)		То	(Month-Day-	V			
Date of Service 1974 RVS/CPT Co		de	Descripti	ion of Services					Plan Office		
(Month-Day-Year)		-			treatment, x-ray, (	etc.)	Charged	!	Use Only		
IMPORTA For payment, I within 72 houl Call Blue Cros	Pre-admission rs of an emer	genc	y admi	ission.	-	to non-en	nergency	hosp	oitalization and		
PHYSICIAN'S I hereby authorize th		it Trust	or its rep	oresentatives to	examine all mo	edical records	pertaining to	this pa	tient's disability.		
Date Signed (Month-Day-	Year)		Physician	n's Signature							
ASSIGNMENT N	OT ACCEPTABL	E UNL	ESS PH	YSICIAN'S I	.R.S. OR SOCI	AL SECURI	TY NUMBE	R FUR	NISHED		
							Telephon				
Physician's Soc. Sec. No. or IRS Taxpayer's ID No.			Physician's Name/Degree (Please Print)				( )				
Street Address					City		State	Ziŗ	)		