SOUND HEALTH & WELLNESS TRUST

Formerly known as Retail Clerks Welfare Trust
P.O. Box 2265 • Seattle, WA 98111-2265
(206) 282-4500 • (TOLL FREE) 1-800-225-7620

MEDICAL-DENTAL-PRESCRIPTION DRUG CLAIM FORM

TYPE OF CLAIM (Check one only) MEDICAL ☐ DENTAL ☐ PRESCRIPTION DRUG ☐

INSTRUCTIONS – PLEASE COMPLETE ALL SECTIONS IN FULL.

(Incomplete information may cause delays in processing)

A. For Medical claims, complete this side of the form and attach an itemized bill.
B. For Dental and Prescription Drug claims, complete this side of the form and have your dentist or pharmacist complete the appropriate sections on the reverse side or attach an itemized bill or pharmacy receipt.
C. If you have other insurance and this plan is secondary on this claim, attach a copy of the other insurance company's explanation of benefits for this claim.

1. PARTICIPANT INFORMATION (TRUST MEMBER)

Name: _____ Social Security # / ID#: _____
Address _____ City _____ State _____ Zip _____
Is this a new address? Yes ☐ No ☐ Male ☐ Female ☐ Birthdate: ____/____/____ Married ☐ Single ☐ Divorced ☐
Day Telephone # ( ) _____ Night Telephone # ( ) _____
Employer Name _____ Local Union # _____

2. PATIENT INFORMATION (TRUST MEMBER OR DEPENDENT)

Patient is: Self ☐ Spouse ☐ Child ☐ Patient's Full Name: _____
Birthdate: ____/____/____ Sex: M ☐ F ☐ If claim is for a child, what is the child's relationship to the Participant? _____
Is dependent child claimed as an exemption on your Federal Income Tax Return? Yes ☐ No ☐
Is dependent child age 19 or over a full time student? Yes ☐ No ☐
If yes, where? _____ Please indicate which quarter/semester ☐ Fall 20__ ☐ Winter 20__ ☐ Spring 20__ ☐ Summer 20__
Is patient employed? Yes ☐ No ☐ Employer's Name: _____
Brief description of illness: _____

3. OTHER INSURANCE INFORMATION

Is this patient (or other family member) covered by any other group health insurance? Yes ☐ No ☐ Medicare ☐
Type of coverage (check all that apply) Medical ☐ Dental ☐ Prescription ☐
Insurance Company Name: _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Which family member is the participant? _____ Birthdate: ____/____/____
Social Security # / ID#: _____ Group #: _____ Group Name: _____
If divorced or legally separated, which parent has custody: _____
Date of divorce or legal separation _____ Which parent claims exemption on their Federal Income Tax return? _____
Which family members are covered by this policy? (Give full names)

_____ _____ _____
_____ _____ _____

4. INJURY / ACCIDENT INFORMATION (Complete only if claim was due to an accidental injury.)

Accident date: ____/____/____ Time: _____ am ☐ pm ☐ Did your injury occur while at work? Yes ☐ No ☐
How did the accident happen? _____

_____

Description of injury: _____

_____

Did another person cause this accident? Yes ☐ No ☐ Can this person be considered legally responsible for your injuries? Yes ☐ No ☐

5. AUTHORIZATION TO PAY PHYSICIAN OR SUPPLIER OF SERVICE (Does not apply to prescription drugs.)

I hereby authorize payment be made directly to the physician or supplier of service shown on the attached itemized statement

_____
PARTICIPANT'S SIGNATURE DATE

6. CERTIFICATION AND RELEASE OF INFORMATION

I certify that the information on this claim is correct and the services were provided as indicated. I also authorize the release of my medical records to Sound Health & Wellness Trust for the purpose of determining my benefits payable under the provisions of this Plan or any other Plan.

_____
PARTICIPANT'S SIGNATURE DATE

7. DENTAL CLAIMS (Dentist completes this section)

FOR CLAIMS INVOLVING PRE-DETERMINATION OF BENEFITS

1. Complete this section. Be sure to itemize charges for each proposed procedure and submit current x-rays (not older than one year).
2. Sound Health & Wellness Trust will review the treatment plan and will provide the estimate of benefits payable. **No predetermined treatment should be started until written determination from the Trust is received. Benefits may be redirected to alternate procedures.**
3. Review the form and benefits estimate with your patient before the work is done.

CHECK ONE: ☐ Pre-determination of benefits ☐ Statement of actual services

DENTIST NAME

MAILING ADDRESS

CITY, STATE, ZIP

DENTIST SOC. SEC. OR T.I.N.	DENTIST LICENSE NO.	DENTIST PHONE NO.

PRE-DETERMINATION REQUIRED for all dental services in connection with orthodontic treatment, crown(s) bridge(s), gold restoration(s), porcelain or gold inlays and onlays and implants.

FOR CLAIMS NOT INVOLVING PRE-DETERMINATION OF BENEFITS

1. Complete this section or attach an itemized bill. Be sure to date and itemize charges.
2. Sign and date the claim form when work is completed.

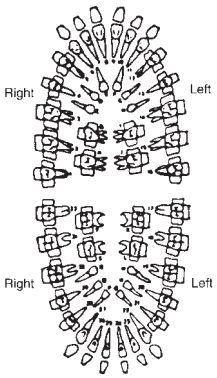
	YES	NO	IF YES, ENTER BRIEF DESCRIPTION & DATES
Is treatment result of occupational illness or injury?			
Is treatment result of auto accident?			
Other accident?			
Are any services covered by another plan?			
If prosthesis is this initial placement?			(IF NO, REASON FOR REPLACEMENT) Date of prior Replacement
Is treatment for Orthodontics?			If services already commenced, enter: Date appliances placed Mos. treatment remaining

Did services include dentures, bridges, crowns or other prosthetic devices? Yes ☐ No ☐

If yes, what type of service? _____ Initial? ☐ Replacement? ☐

If replacement, give date of original or prior placement _____

Identify missing teeth with "X"



EXAMINATION AND TREATMENT PLAN — List in order from tooth No. 1 through tooth No. 32 — use charting system shown.

Tooth # or Letter	Surface	DESCRIPTION OF SERVICE (Including X-Rays, Prophylaxis, Materials Used, Etc.) PLEASE ATTACH ITEMIZED STATEMENT	Date Service Started MO.	DAY	YR.	Date Service Completed MO.	DAY	YR.	Procedure Number		CHARGE	
											TOTAL	

I hereby certify that the procedures as indicated above by date have been completed.

_____
SIGNED (DENTIST)

8. PRESCRIPTION DRUG CLAIMS (Attach Itemized Pharmacy Receipt or Pharmacist Complete this Section.)

NAME OF ILLNESS OR ACCIDENT REQUIRING MEDICATION / PATIENT NAME	NAME OF DRUG AND STRENGTH	PRESCRIPTION NUMBER	DATE FILLED	NO. DAYS SUPPLY	QUANTITY PURCHASED	TOTAL COST INCL. TAX
1.						
PATIENT NAME:						
2.						
PATIENT NAME:						
3.						
PATIENT NAME:						
4.						
PATIENT NAME:					TOTAL	

PHARMACY NAME: _____

PHARMACY PHONE # _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHARMACIST'S SIGNATURE _____ DATE _____