SOUND HEALTH & WELLNESS TRUST

P.O. Box 2265 • Seattle, WA 98111-2265
(206) 282-4500 • 1-800-225-7620

MEDICAL-PRESCRIPTION DRUG CLAIM FORM

TYPE OF CLAIM (Check one only) **MEDICAL** ☐ **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 Prescription Drug claims, complete this side of the form and 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: _____ Member 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 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