

**SEATTLE AREA PLUMBING & PIPEFITTING
INDUSTRY HEALTH & WELFARE TRUST**
Administered by Zenith Administrators, Inc.
P. O. Box 91076 - Seattle, WA 98111-9176
(206) 352-9728 - (TOLL FREE) 1-888-406-3246

**Medical-Dental-Vision-Prescription Drug
Claim Form**

TYPE OF CLAIM (check one only) **MEDICAL** **DENTAL** **VISION** **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, Vision and Prescription Drug claims, complete this side of the form and the appropriate sections on the reverse side.
- 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

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

2. PATIENT INFORMATION (PARTICIPANT OR DEPENDENT)

Patient is: Self Spouse Child Patient's Full Name: _____
Birthdate: ____ / ____ / ____ Sex: M F If claim is for child, what is the child's relationship to the Participant? _____
Is dependent child age 19 or over a full time student? Yes No
Is patient employed? Yes No Employer's Name: _____
Brief description of illness: _____

3. OTHER INSURANCE INFORMATION

Is this patient (or other family member) eligible for any other group health insurance? Yes No Medicare
Type of coverage (check all that apply) Medical _____ Dental _____ Vision _____ Prescription Drug _____
Insurance Company Name: _____
Address: _____ City _____ State _____ Zip _____
Which family member is the participant? _____ Birthdate: ____ / ____ / ____
Social Security #: _____ - ____ - ____ Group #: _____ Group Name: _____
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 this 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 the Administrative Manager for the purpose of determining my benefits under the provisions of this Plan or any other Plan.

PARTICIPANT'S SIGNATURE DATE

7. DENTAL CLAIMS (COMPLETE THIS SECTION.)

Is this claim a Pre-Treatment Estimate or Statement of Actual Services (Check One)

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. _____

Please attach itemized pre-treatment estimate or itemized billing.

8. VISION CLAIMS (COMPLETE THIS SECTION.)

Date of last complete eye exam _____ Date glasses ordered _____ Date glasses delivered _____

Type of lenses prescribed: Single Bifocal Tri-focal Contacts Other _____

Are any of these charges for lost, broken or stolen glasses? Yes No

Are these charges for duplicate or spare glasses? Yes No

Please attach itemized bill.

9. 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						
5. PATIENT NAME						
6. PATIENT NAME						
7. PATIENT NAME						
8. PATIENT NAME						

PHARMACY NAME _____

TOTAL

PHARMACY PHONE # _____ ADDRESS _____

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