NATIONAL ELEVATOR INDUSTRY
HEALTH BENEFIT PLAN

MEDICAL CLAIM FORM

Mail with itemized bill(s) to:
NATIONAL ELEVATOR INDUST
HEALTH BENEFIT PLAN
P.O. Box 477
Newtown Square, PA 19073-0

Telephone: 1-800-CLAIM11
or 1-800-252-4611

Instructions: Fully complete ALL below.

MEMBER

Name _____ (LAST / FIRST / MIDDLE INITIAL) Social Security No. _____

Address _____ (STREET) Birthdate _____ (MONTH / DAY / YEA)

_____ (CITY / STATE / ZIP CODE) Telephone ( ) _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Surviving Spouse (Member Deceased) Local Union No. ___

Employer Name and Address _____

SPOUSE

Name _____ (LAST / FIRST / MIDDLE INITIAL) Social Security No. _____

Employer Name and Address _____

PATIENT

Name _____ (LAST / FIRST / MIDDLE INITIAL) Social Security No. _____

Sex: ☐ M ☐ F Relationship to Member: ☐ Self ☐ Spouse ☐ Surviving Spouse ☐ Child ☐ Other _____

Address (If different from Member) _____ (STREET) Birthdate _____ (MONTH / DAY / YEA)

_____ (CITY / STATE / ZIP CODE) Telephone ( ) _____

Employer Name and Address _____

If patient is child age 19 or over, is patient a full-time student? ☐ Yes ☐ No

Name and address of school attending _____

Is patient covered under other group health coverage? ☐ Yes ☐ No Medicare? ☐ Yes ☐ No

Name of group/employer _____ Name of insured _____

Name and address of insurance company _____

PLEASE ATTACH "EXPLANATION OF BENEFITS" FROM OTHER COVERAGE, INCLUDING MEDICARE

Nature of illness or injury _____

Was illness or injury related to an accident? ☐ Yes ☐ No Accident date _____ (MONTH / DAY / YEAR)

Was another party at fault? ☐ Yes ☐ No Accident location _____

Was illness or injury in any way work related? ☐ Yes ☐ No _____

I agree to reimburse the Health Benefit Plan to the extent of any overpayment which is in excess of the amounts payable under provisions of the I
ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMAT
WITH INTENT TO INJURE, DEFRAUD OR DECEIVE, MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND SUBJECT TO L
OF HEALTH PLAN COVERAGE.
I certify that the statements hereon are complete and accurate to the best of my knowledge and that I am claiming benefits only for charges incu
by the patient named above. I further authorize the release of any medical information necessary to process this claim. A photocopy of
authorization shall be considered as effective and valid as the original.

Date _____ (MONTH / DAY / YEAR) Signature of Claimant (or Parent if Minor) _____

IMPORTANT: FULLY ITEMIZED BILL(S) MUST ACCOMPANY THIS FORM—SEE OTHER SIDE.

MED-5001-1/94-500000