CARPENTERS
BENEFIT PLANS

1419 Hampton Ave
St. Louis, MO 63139

DATE:

MEMBER NAME:
ADDRESS:

MMR ID#
PLAN : CARPENTERS
PATIENT
DOB :
PROVIDER :
SVCDATE
CLAIM #
Group # : 76415833
MAIL ID : MD WB03 ND
LETTER : 1325CARP

RE: IMPORTANT INFORMATION NEEDED FOR YOUR MEDICAL CLAIMS -
THIRD PARTY/SUBROGATION INQUIRY

We need additional information before we can process this claim. It is very important that we receive this information as soon as possible, but no later than 45 days from the date you receive this letter.

1 We need you to **fully complete, sign, and date and return the following in the enclosed envelope.**The enclosed Questionnaire.
2 If you were involved in a car accident, send a copy of the declaration page from your auto insurance policy in effect at the time of your accident.
3 If you have a police report, please also send a copy.

Failure to provide all the necessary information will delay any benefits to which you may be entitled.

The St. Louis - Kansas City Carpenters Regional Health Plan states if another third-party pays claims related to medical, dental, or disability benefits arising from an accident or other event, the Plan has the Right of Recovery through Subrogation.

Please refer to your plan's claim and appeal procedures.

If you would like to review the questionnaire with a Carpenters' Fund Office representative, please call 1-877-232-3863 from 8 am CST to 4:30 pm CST on regular business days.

Reset form

1. Accident Details:

   Date/Time: _____

   City/State:_____

   What happened:

   _____

   Injuries:

   _____

2. Is the treatment related to an accident or injury?
   ◯ Yes ◯ No
   If yes, have you or will you be filing a claim report for this accident?
   ◯ Yes ◯ No

3. Is the accident or illness the result of a work or school related injury, including self-employment?
   ◯ Yes ◯ No

4. Is the treatment the result of a hazardous activity (any activity that has an increased threat of danger or risk of bodily harm), including extreme sports, or racing?
   ◯ Yes ◯ No

5. Were you under the influence of drugs or alcohol at the time of the injury?
   ◯ Yes ◯ No

***If you answered "NO" to all the above questions**, you can stop here, sign and date this letter, and return it to us. Please note that claims cannot be processed until this information is received. Please mail the letter or call 1-(877)-232-3863 to provide your responses.

***If you answered "YES" to any of the above questions, please continue.**

6. If this is a motor vehicle accident, please provide the following information regarding your auto insurer:

   Auto Insurer: _____

   Claim Number: _____

   Policy Number: _____

   Adjuster Name: _____

   Insurer address/phone/fax:

   _____

7. If this claim may be the result of another party's negligence, please provide the name of the third party below AND the contact information for the responsible party's insurance carrier:

   Name of Third Party: _____

   Responsible Party's Insurance Carrier:

   _____

   Policy Number: _____

   Claim Number: _____

   Adjuster Name: _____

   Insurer address/phone/fax:

   _____

8. If this loss was work-related, please answer the following:

   WC Employer: _____

   WC Insurer: _____

   WC Claim Number: _____

   WC Adjuster: _____

   WC Insurers address/phone/fax: _____

   _____

9. Have you received any payment/settlement in connection with this injury? ◯ Yes ◯ No
   If yes, please describe:

   _____

   If yes, please provide settlement date: _____

10. Have you retained an attorney? ( ) Yes ( ) No
    If yes, please provide:

    Attorney Name: _____

    Address: _____

    Phone/Fax Number: _____

11. For any motor or recreational vehicle accident, please answer the following:

    A. Were you the driver or passenger?
    ◯ Driver ◯ Passenger

    B. Were you and all occupants wearing seatbelts?
    ◯ Yes ◯ No

    C. If the injury involved any 2-/3-/4- wheeled motorized vehicles, were you and all riders wearing protective headgear?
    ◯ Yes ◯ No

    D. Was the treatment related to competition racing or extreme sports?
    ◯ Yes ◯ No

For all accidents/injuries/illnesses, please provide the following documents:

- Police Report, police citations/tickets, or Victims Assistance Statements related to the injury/illness
- Any relevant correspondence from the insurance company regarding the injury/illness

I HERBY CERTIFY THE INFORMATION ON THIS FORM IS TRUE AND ACCURATE. I AUTHORIZE YOU TO OBTAIN ANY INFORMATION THAT MAY BE RELATED TO THIS ACCIDENT.

In accordance with the provisions of this Health Plan, I agree that if payment should be received from any other person or organization responsible for injuries sustained, whether by legal actions, settlement or otherwise, I will reimburse the Plan to the extent of the benefits provided, immediately upon receipt.

I also authorize and direct reimbursement to you of the amounts otherwise payable to me or on my behalf to others, but not to exceed the benefits paid under this Health Plan, as a result of the injuries sustained.

Plan Member's Signature_____ Date_____

Patient Signature (if over 18)_____ Date_____

Please provide a daytime phone number in case additional information is needed: _____

Thank you for your help. If you have any questions, please contact the Benefit Office at 1-877-232-3863.

Enclosure