MID AMERICA
CARPENTERS BENEFITS
1419 Hampton Ave
St. Louis, MO 63139

MEMBER NAME:
ADDRESS:

CLAIM #
LETTER: SUBROCARP
GROUP #: 76415833
ID#
PATIENT
DOB
PROVIDER :
SERV DT:

Pending Claim Questionnaire

Mid-America Carpenters Regional Council Health Fund - Southern STLKC Region (Carpenters Plan)
1419 Hampton Avenue, St. Louis, MO 63139
Phone : (314) 644-4802 Email : benefits@laborfunds.org Fax : (314) 678-1110

We recently received a claim for the patient listed below that may be the result of an accident or injury. We need additional information before we can process this claim.
We need you to **fully complete, sign, and date** the enclosed Questionnaire.

A: Patient Information

First and Last Name | Date of Birth | Last Four of Social Security XXX-XX-

◯ I am the Member ◯ I am the Member's Spouse ◯ I am the Member's Dependent

B: Please briefly state the reason for this claim and how it occurred. (We must have this information to process the claim)

C: When did the described injury/accident/illness occur (Date): _____

D: Did this happen while patient was at work, including self-employment? ◯ **Yes** ◯ **No**

E: Where did this incident/injury/illness occur?

◯ **YOUR PROPERTY**

◯ **PUBLIC ESTABLISHMENT** (e.g. store, restaurant, business)

◯ **PUBLIC SPACE** (e.g. park, street, sidewalk)

◯ **OTHER** (MUST SPECIFY)

Reset form

F: Was this injury/accident related to a motor vehicle accident? ◯ **Yes** ◯ **No**

G: For ANY motor or recreational vehicle accident, please answer the following:

- Were you the driver or passenger?
◯ **Driver** ◯ **Passenger**

- Were other vehicles involved?
◯ **Yes** ◯ **No**

- Was the treatment related to competition racing or extreme sports?
◯ **Yes** ◯ **No**

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

If applicable to your injury/accident/illness, please provide the following documents:

- **Police Report, police citation/tickets, or victims Assistance Statements related to the injury/illness.**
- **Any relevant correspondence from the insurance company regarding the injury/illness.**
- **A copy of the auto insurance declaration.**

H: Have you retained an attorney? ◯ **Yes** ◯ **No**

Attorney Name: _____
Address: _____
Phone/Fax Number: : _____

I: If this claim may be the result of another party's negligence, please provide the name of the third party below and the contact details.

Name of Third Party: _____
Responsible Party's Insurance Carriers: _____
Policy Number: _____
Claim Number: _____
Adjuster Name: _____
Insurer address/phone/fax: _____

Have you received any payment/settlement in connection to this injury? ◯ **Yes** ◯ **No**

If yes, please provide the settlement date: _____

I HEREBY 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, pelase contact the Benefits Office at (314) 644-4802.