# Medical – Dental Claim Form

# ALASKA LABORERS HEALTH AND SECURITY FUND

A Self-Funded Health Plan

# P.O. Box 34567, Seattle, WA 98124-1567

For Toll-Free Assistance Nationwide Call:

**Welfare & Pension Administration Service** 

Claims Office 1-800-331-6158

**Instructions:** 

Complete this form, attach all itemized bills, send to the plan

Administrator at the address above, & keep a copy for your records

Part I – TYPE(S) OF CLAIM:	Check type(s):	Medical	Dental		
Part II – EMPLOYEE DATA:					
Employee Name: (First Name)	(Last Name)	Social Security No	ე		-
Mailing Address: (Street)	(City)	(	State)	(Zip)	
PART III – PATIENT DATA:	Claim is for:	imployee Spous	e Depend	lent Child	
Patient Name:			Birth Date:/.	/	
If child is age 19 or older, is child a full If yes, current semester enrollment form If no, does child have a developmental Handicap, or live at home? Yes	must be on file	Child St	dependent child, in ep Child Legal C	Guardianship	-
PART IV – OTHER INSURANCE	INFORMATION:				
Does patient have other health insurance company/plan administrator's name, add 1	lress, telephone #, policy/pl		rage:	Medical	olicy/plan: Insurance  Dental  Dental
Is spouse employed? Yes No	If yes, please write nar	me, address and telepho	ne number of empl	oyer and/or u	nion local:
PART V – CLAIM INFORMATION	ON (complete only appl	icable information):			
Are expenses related to an accident? Automobile Employment-Related: Name, address	Yes No If yes, indica	te date of accident	// a		
Briefly describe accident:					<del></del>
Note: If claim is related to an acc	ident, you will receiver an "a	ccident questionnaire". I	Respond promptly to	expedite claim	processing.
PART VI – AUTHORIZATION TO I In order to process a claim for benefits, I au Inc. (WPAS) and the planholder, or their examination results or diagnosis. This auth defraud nay insurance company or other per I AUTHORIZE BENEFIT PAYMENT TO	thorize any physician, hospita representatives, any informa orization shall be considered arson files a statement of claim	ation regarding my and/ovalid for the duration of to the containing any false, in	or my dependent's he claim. Any perso complete or misleadi	nealth history, on who knowing ing information	symptoms, treatment, ngly and with intent to n is guilty of a felony.
FORM. Yes No					
Eligible Participant's Sig	nature		Date /		231A 3/00

## **CLAIM FILING TIPS**

WE WANT YOUR CLAMIS TO BE PAID ACCURATELY AND TIMELY. USING THE FOLLOWING TIPS WILL HELP US GIVE YOU BETTER SERVICE.

### **DOs**

- Answer all the appropriate questions and sign the claim form.
- Always send your claim form and an itemized statement of charge which includes:
  - 1. Employee name
  - 2. Patient name
  - 3. Provider name & Tax ID number
  - 4. Dates of service
  - 5. Diagnosis (preferably with code number)
  - 6. Types of service (preferably with code number)
  - 7. Charges for each type of service
- Try to batch your claim submissions (send several itemized bills at one time). This will help us keep costs down.
- If you have insurance coverage, please remember to submit the claim to the primary insurance plan first. (Refer to your health benefit booklet, "coordination of benefits" section to determine which plan is primary). When you receive the "explanation of benefits" statement back from the primary plan, submit the claim to the secondary plan by sending that plan's claim form, a copy of the bill and a copy of the primary plan's EOB (explanation of benefits statement).

**Exception:** The Administration Office will internally coordinate the processing of a claim, if both plans are administered by WPAS.

- Always pre-certify "non-emergency surgeries and/or hospital confinements" by calling PRO-West at (800) 783-8606
- Have your dentist submit a "pre-treatment dental plan" for all claims expected to exceed \$400 to the Administration Office. This will let you know your "out-of-pocket expenses" **before** services are rendered.

#### **DON'Ts**

- Never send a "balance forward bill" to the Administration Office.
- Make certain you know who is going to file your claim. Do not submit a claim yourself, if your health care provider dells you they will submit the claim for you. Duplicate claim filing adds to the administrative expense of operating our plan.