

Return this form to:
 Michigan Conference of
 Teamsters Welfare Fund
 2700 Trumbull Avenue
 Detroit, MI 48216



****FOR THE REIMBURSEMENT OF OPTICAL BENEFITS****

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)						1a. INSURED'S I.D. NUMBER (For Program in Item 1)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)											
CITY			STATE			CITY			STATE														
ZIP CODE			TELEPHONE (Include Area Code) ()			ZIP CODE			TELEPHONE (Include Area Code) ()														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						11. INSURED'S POLICY GROUP OR FECA NUMBER											
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>											
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)						b. EMPLOYER'S NAME OR SCHOOL NAME											
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
SIGNED _____						DATE _____						SIGNED _____											
14. DATE OF CURRENT: MM DD YY				ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____		17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.											
23. PRIOR AUTHORIZATION NUMBER																							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSTD Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #			
NPI _____		NPI _____		NPI _____		NPI _____		NPI _____		NPI _____		NPI _____		NPI _____		NPI _____		NPI _____					
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH # ()											
SIGNED _____						DATE _____						SIGNED _____											
a. _____						b. _____						a. _____											
b. _____						b. _____						b. _____											

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION