

PLUMBERS LOCAL UNION NO. 690
MAJOR MEDICAL PLAN

RE: DIRECTIONS FOR COMPLETING THE MEDICAL CLAIM FORM.

- PART A - The member must complete this part of the form, stating his name, address, phone number, social security number and the name and policy number of any other insurance. On the last line of Part " A" , he must state the date the form was completed and his signature, which is most important.
- PART B - Now covered by Blue Shield card.
- PART C - Now covered by Blue Shield card.
- PART D - Now covered by Blue Shield card.
- PART E - This part of the form deals with the services of long-term illness where private duty nursing care or physical therapy treatments were required. If these types of services were rendered, list the dates and charges of the services.
- PART F - All the services and supplies covered by this part of the form are listed on the form. State total amount charged for member and dependents on the line provided for such services.
- PART G - Physician's Certification - It is not necessary for the doctor to sign this form. The receipts must contain all the information as listed in the below note.
- PART H - The member must complete this part stating that he has full knowledge of the rules and regulations of the Plan; along with the rights of the Board of Trustees regarding fraud.

NOTE: We must have the **ORIGINAL PAID RECEIPTS** covering these expenses. (Copies accepted if accompanied by explanation of benefits from another insurance carrier). The receipt should state; **DATE OF SERVICE, PROVIDER'S NAME, TYPE OF SERVICE, DIAGNOSIS, PATIENT'S NAME, CHARGES AND PAYMENT**, which must be in full. We cannot accept as proof-of-payment: canceled checks, providers' statements, ledger cards or account statements. Please request a receipt to be mailed to you if you are paying by mail.