SOUTHERN CALIFORNIA DRUG BENEFIT FUND

P.O. Box 27920, Los Angeles, CA 90027-0920

HOSPITAL...MEDICAL...SURGICAL

TO BE COMPLETED BY EMPLOYEE

Please attach itemized bills

1. Employee's Name: _____ Marital Status: Single ☐ Married ☐ Divorced ☐
   Home Address: _____ City _____ State _____ Zip Code _____
   Social Security Number: _____ Date of Birth _____ Sex _____ Area Code _____ Phone No _____
   Employer: _____ Store No. ___ Area Code ___ Phone No. _____ LOCAL _____
   Address: _____ City _____ State _____ Zip Code _____

2. Claim is made for: (check one) Self ☐ Spouse ☐ Child ☐
   (If claim is for Spouse or Child, please complete the following:

Name of Dependent	Date of Birth	Social Security No.	Sex

3.

Authorization to release information. I hereby authorize any physician or any hospital to release any information acquired in the course of my examination or treatment.	_____ Signed (Patient, or Parent if Minor) Date

4. If patient (other than employee) is employed, give name and address of employer _____

5. Date of injury or beginning of illness _____ Was the injury or illness caused by patient's employment? Yes ☐ No ☐
   What is the nature of injury or illness _____

6. ***IF PATIENT WAS INJURED, ANSWER THE FOLLOWING:***
   a. Where did the injury occur? _____ Date and Hour _____
   b. What was patient doing when the injury occured? _____

   First date patient unable to work because of this disability _____ ___
   Date returned to work _____ _____ Date expected to return to work _____ _____

IMPORTANT-FAILURE TO COMPLETE THIS SECTION WILL DELAY THE PROCESSING OF THIS CLAIM.

Are there any other benefits provided for this claim from any other group plan or Medicare? Yes ☐ No ☐ If Yes, please answer below.
Name of employer sponsoring other insurance _____
Name of employee belonging to other group _____
Group Policy No. and/or Subscriber No. _____
Name, address and telephone number of where you would submit a claim for other insurance: _____
(If above answered YES please be sure to send copies of the same bills to the other company.)

8. I hereby certify the statements hereon and attached to be complete and accurate and I authorize the release of necessary information from any person or institution rendering care, or any person or organization in possession of insurance or other benefit information concerning me or my dependents to the SOUTHERN CALIFORNIA DRUG BENEFIT FUND for clarification of this claim or interpretation on my behalf. A copy or photocopy of this authorization shall be as valid as the original.
   Employee Signature: _____ Date: _____

CLAIM FORM MUST BE SUBMITTED TO THE BENEFIT FUND OFFICE WITHIN 12 MONTHS OF THE DATE SERVICE IS PROVIDED

REVERSE SIDE IS FOR PHYSICIAN'S STATEMENT

ATTENDING PHYSICIAN'S STATEMENT

(OR Attach Certified Physician's Statement)

1. Patient's Name: _____ Age _____

2. Nature of sickness or injury (Describe complications, if any) _____

_____

3. Did this sickness or injury arise out of patient's employment? Yes ☐ No ☐
If "Yes," explain _____

_____

4. Is disability due to pregnancy? Yes ☐ No ☐
If "Yes," what was approximate date of commencement of pregnancy? _____

5. SURGICAL PROCEDURES PERFORMED	PROCEDURE CODE	DATE	CHARGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Where was this surgery performed? ☐ OFFICE ☐ HOSPITAL IN-PATIENT ☐ HOSPITAL OUT-PATIENT

6. Indicate place and dates of medical treatment:

	Dates of Service	Procedure Code	Charge Per Call
Office	_____	_____	$ _____
Home	_____	_____	$ _____
Hospital	_____	_____	$ _____

7. What other services, if any, did you provide patient? (Itemize, giving dates and fees) _____

_____

_____

8. To your knowledge, does patient have other insurance covering the services provided: Yes ___ No ___ If yes, please identify:

☐ Medicare ☐ Medi-Cal ☐ Champus ☐ Other (specify) _____

_____

9. The patient has been continuously disabled (unable to work) from _____ through _____

If still disabled, when should patient be able to return to work? _____

ASSIGNMENT OF MEDICAL BENEFITS: I hereby authorize payment of benefits, otherwise payable to me, directly to the attending physician. I understand I am financially responsible to the physician for charges not covered.

Date _____ *Signed* _____
MEMBER

I hereby authorize the Benefit Fund to examine the patient's medical records upon presentation of authorization signed by the patient or a qualified person.

_____
(TYPE OR PRINT NAME OF PHYSICIAN) (DATE)

_____
(SIGNATURE OF PHYSICIAN) (DEGREE) (SPECIALTY) (PHONE)

_____
(ADDRESS: NUMBER AND STREET) (CITY) (STATE) (ZIP CODE)

*** * IMPORTANT * ***

ENTER TAX IDENTIFICATION NUMBER

Employer Identification No. _____ or Social Security No. _____

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