

FOR OFFICE USE ONLY



NATIONAL ORGANIZATION OF INDUSTRIAL TRADE UNIONS INSURANCE TRUST FUND
SURGICAL-MEDICAL CLAIM FORM

148-06 HILLSIDE AVENUE • JAMAICA, N.Y. 11435-3393 • (718) 291-3434



SMCF 0104 10M

Member's Name and Home Address (Please Print) / Nombre y direccion de la casa del Miembro (usar letra imprenta)
Last / Apellido First / Nombre Middle Initial / Inicial Social Security Number No. Seguro Social
Date of Birth / Fecha nacimiento Mo. / Mes Day / Dia Yr. / Ano
Male / Varon Female / Hembra

Number / Numero Street / Calle City / Ciudad State / Estado Zip Code / Zip Employer / Nombre del Patrono

Marital Status / Estado Conyugal: Single / Soltero Divorced / Divorciado Married / Casado Widowed / Viudo
Please indicate Spouse's name / Indique nombre del Conyuga Spouse's Social Security No. Spouse's Date of Birth / Fecha Nacimiento

Is your Spouse employed? / Esta empleado? Spouse's employer's name and complete address / Nombre y direccion completa del patrono del conyuga

Is patient also covered by any Group Health Plan or HMO provided by:
a. Another employer, union, trade association, school, or arrangement of coverage for individuals in a group?
b. Medicare/Medicaid, or any other federal, state, or government agency?
Esta el paciente cubierto por cualquier Plan de Salud de Grupo o HMO suministrado por:
a. Otro patrono, union, asociacion de oficios, escuelas o un arreglo de cobertura individual en un Grupo?
b. Medicare o Medicaid, o cualquier otra agencia federal, estatal o gobierno?

Was illness or injury due, in any way, to patient's occupation? / La enfermedad o lesion se debieron en forma alguna a la ocupacion del paciente?
If "Yes," please describe in "Remarks."

Is claim due to an accident? / La reclamacion se debe a un accidente?
If "Yes," give date and explain in "Remarks" where and how injury occurred.
a. If auto accident, circle whether patient was the owner, driver, passenger or pedestrian and whether vehicle was private passenger, taxi, bus, truck, or other.
b. For all accidents: Does the patient expect to receive, or has the patient received, payment for these expenses from another source as the result of a lawsuit or settlement?

Remarks: / Comentarios M C P

Dependent Information (Complete only if Patient is a Dependent) / Informacion sobre el Dependiente (solo si el paciente es dependiente)
Name of Dependent / Nombre del Dependiente Relationship / Relacion: Spouse / Esposa Child / Hijo Other (specify) / Otra (explicar)
Date of Birth / Fecha nacimiento Mo. / Mes Day / Dia Yr. / Ano Marital Status / Estado Conyugal: Single / Soltero Divorced / Divorciado Married / Casado Widowed / Viudo

If claim is for dependent child 19 or older: / Si la reclamacion es para hijo dependiente de 19 anos o mas:
Is child enrolled as full-time student? / Esta matriculado como estudiante de tiempo completo?
Is that child employed? / Ese hijo esta empleado?

Name and complete address of school or employer and Dependent's Social Security Number / Nombre y direccion completa de la escuela o patrono y No. de Seguro Social del Dependiente:

I HEREBY AUTHORIZE THE NOIU INSURANCE TRUST FUND TO PAY THE AMOUNT OTHERWISE DUE AND PAYABLE TO ME, TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED AND/OR PAID BY THIS ASSIGNMENT.
MEMBER'S SIGNATURE DATE
POR LA PRESENTE AUTORIZO A NOIU INSURANCE TRUST FUNDA PAGAR LA CANTIDAD QUE DE OTRA MANERA SERIA ADEUDADA Y PAGADERA A MI, A LA FIRMA QUE SIQUE, YO ENTIENDO QUE SOY RESPONSABLE FINANCIERAMENTE POR LAS CARGOS NO CUBIERTOS Y/O PAGADOS POR LA PRESENTE ASIGNACION.
FIRMA DEL MIEMBRO FECHA
I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. BENEFITS ARE NOT AVAILABLE UNDER ANY OTHER GROUP PLAN EXCEPT AS INDICATED ABOVE.
MEMBER SIGN HERE
YO CERTIFICO QUE LA INFORMACION OFRECIDA ES CORRECTA Y AUTORIZO A QUE SE DE A CONOCER CUALQUIER INFORMACION QUE SEA NECESARIA PARA EL PROCESO DE ESTA RECLAMACION. LOS BENEFICIOS NO ESTAN DISPONIBLES BAJO NINGUN OTRO PLAN DE GRUPO, EXCEPTO COMO SE INDICA ARRIBA.
EL MIEMBRO FIRMA AQU!

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER
Name of Patient Last First Middle Initial Name of Employee or Member Last First Middle Initial
Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP) Mo. Day Yr. Date Patient First Consulted You for this Condition Mo. Day Yr. Has Patient ever had Same or Similar Symptoms? Yes No
Date(s) of Service Units or Days Place of Service ICD-CM Diagnosis Code CPT/HCPCS Procedure Code MOD. MOD. Description of supplies or, if needed, additional medical service information Charges
Physician's or Supplier's Name, Address, Zip Code & Telephone No. Your Patient's Account No. Total Charge Amount Paid Balance Due
Federal Tax Reporting No. (IRS requirement) SSN EIN/TIN Signature of Physician or Supplier Signed Date



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INSTRUCTIONS

TO MEMBER

1. Take a claim form with you when you go to a doctor. The doctor must complete his part of the claim form.
2. Fill out and sign your part of the claim form. If you wish the payment, if any, to be sent directly to the doctor, also sign the "Assignment of Benefits" section.
3. If the services rendered include diagnostic laboratory or x-ray procedures not done in the doctor's office, or for ambulance transportation, you must attach an itemized bill.
4. If claiming benefits supplementary to Medicare or other insurance, you must submit the "Explanation of Benefits" from the Medicare/insurance processor.
5. After the claim form has been completely filled in and signed by both the doctor and member, mail it promptly to:

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TO DOCTOR

1. Please print or type legibly.
2. Please answer all pertinent questions and enter all necessary information. Information omitted will delay the processing until completed.
3. If an unusual procedure is performed, submit a description or operative and/or pathology report.
4. If an excision is involved, describe method of excision, size and location of lesion.

INSTRUCCIONES

AL MIEMBRO

1. Lleve un modelo de reclamacion con usted cuando vaya a ver a un medico. El doctor debe llenar y firmar su parte del modelo de reclamacion.
2. Llene y firme su porcion del modelo de reclamacion. Si usted quiere que el pago - si hay pago - se evie directamente al doctor, firme tambien la seccion "Asignacion de Beneficios."
3. Si los servicios rendidos incluyen diagnostico de laboratorio o procedimientos de rayos-x no hechos en la oficina del doctor, o por transporte en ambulancia, usted debe acompañar una factura detallada.
4. Si esta reclamando beneficios bajo "beneficios suplementarios a Medicare o otro seguro," usted debe presentar la "Explicacion de Beneficios" del procesador de Medicare o del seguro.
5. Despues de que el modelo de reclamacion este completamente lleno y firmado por el doctor y el miembro, enviase pronto por correo a:

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AL DOCTOR

1. Escriba a maquina o letra de imprenta, por favor.
2. Sirvase responder todas las preguntas pertinentes y anotar toda la informacion necesaria. Omision de informacion demorara el proceso hast que sea completada.
3. Si se efectua un procedimiento desusado o poco usual, acompañe una descripcion, de la operacion y/o informe de patologia.
4. Si ocurriera una excision, describa el metodo empleado, el tamano y logar de la lesion.

CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF DATE OF SERVICE

PLACE OF SERVICE CODES:

1-(IH) — Inpatient Hospital
2-(OH) — Outpatient Hospital
3-(O) — Doctor's Office
0-(OL) — Other Locations

4-(H) — Patient's Home
5- — Day Care Facility (PSY)
6- — Night Care Facility (PSY)
A-(IL) — Independent Laboratory

7-(NH) — Nursing Home
8-(SNF) — Skilled Nursing Facility
9- — Ambulance
B- — Other Medical/Surgical Facility