

ELECTRICAL WORKERS I.B.E.W. #292 FRINGE BENEFITS PLAN

5100 Gamble Dr, Suite 430
St. Louis Park, MN 55416

1(952) 591-7733/(800) 368-9045
Fax 1(952) 591-7728

Medical ID# - PIB XZ _____
Patient _____
Provider _____

Claim# _____
Date of Service _____

We have received a claim for the above named patient. Based on the claim diagnosis it appears that it may be related to an accident/injury. Please complete the following information and submit within **thirty (30) days**. We are unable to process the claim(s) until the information is received.

1. Was the injury/accident work related? Yes___ No___

If the injury/accident was work related, state the employer's name and address: _____

2. Was the injury/accident due to a motor vehicle accident or use of a motor vehicle? Yes___ No___

If yes, please submit claims to no fault auto carrier.

3. If the injury/accident occurred at another person's home or place of business, please state the following:

Name of the person/business: _____

Address where the injury/accident occurred: _____

Has or will legal action be taken regarding this injury/accident? Yes___ No___

If yes, state the name and address of your attorney: _____

4. **For the above date of service please indicate in detail why the patient was seen:**

5. I certify that the above information is true and correct. I acknowledge that any fraudulent or misleading statements or representations, or withholding of information on this Claim Information Form are grounds for denial of this claim by the IBEW 292 Health Care Plan, it may also result in termination of medical benefits for up to 1 year.

6. Patient signature _____ 7. Date of Signature: _____
(or signature of parent or guardian if claimant is a minor)

*This information is necessary to determine if there is liability for the injury or accident. Failure to timely return this form will result in denial of all claims related to the accident or injury. If you have any questions please feel free to contact our office.