IBEW 292 Benefits Office

6700 W. Broadway Ave, Ste B
Brooklyn Park, MN 55428

(763) 493-8830 | (800) 368-9045 | ibew292benefits.org | claiminfo@ibew292benefits.com

PROVIDER STATEMENT

It is the responsibility of the member to see that all sections of this form are complete, questions answered and medical records related to the diagnoses and the form returned to the plan office at **6700 W. Broadway Ave., Suite B, Brooklyn Park, MN 55428 Ph. (763) 493-8830 or (800) 368-9045 Fax (763) 416-6196 Email:** claiminfo@ibew292benefits.com

1. Patient's Name _____

2. Name of illness/injury _____

   Was patient confined to a hospital overnight? _____

3. Surgical procedures, if any, _____ Date performed _____

4. Date patient first consulted you about this condition. _____

5. Date of most recent treatment _____

6. Frequency of treatment(s) _____

7. If you are pregnant, please give delivery date. _____

8. Date employee first unable to work due to disability. _____

9. Is the employee now, and has the employee been, continuously disabled from performing their job from the above date?
   Yes _____ No _____ Remarks if any. _____

10. When will the employee be able to return to work? (Give approximate date) _____

11. Is the disability the result of illness or injury arising out of or in the course of employment: Yes _____ No _____
    If yes, please explain. _____

Date signed _____ **Doctor's Signature** _____

Doctor's Name _____ **Address** _____

Phone _____ **Doctor's I.D or NPI. Number** _____

I hereby authorize release of medical information to IBEW Local #292 Health Care Plan to receive Loss of Time Benefits and do certify that the above statement is true. I also authorize release of workability to the Local IBEW 292 Hiring Hall.

Date _____ Employee's Signature _____

Current as of October 2026

4835-1152-5490.2