

# AGC – International Union of Operating Engineers Local 701 Health & Welfare Trust Fund

Mailing Address 15 - 82nd Drive, Suite 110 Gladstone, Oregon 97027

Phone (866) 697-5750 or (503) 657-9740 • Fax (503) 657-9737 • Website www.agc-iuoe701trusts.com

Administered by:  
Welfare & Pension Administration Service, Inc.

## Non-Participating Provider Medical / Vision / Prescription Claim Form

F07

**Instructions:** Please complete this form, attach all itemized bills, send to the appropriate Claims Office, and keep a copy for your records.

**Mail Member Paid Medical, Vision and Prescription Claims to:**

15 82<sup>nd</sup> Drive, Suite 110  
Gladstone OR 97027

**PART I – TYPE(S) OF CLAIM:** Check type(s):    Medical    Vision    Prescription

**PART II – EMPLOYEE INFORMATION:**

Employee Name: \_\_\_\_\_ Identification #(as shown on your health ID card): \_\_\_\_\_  
(First Name) (Last Name) (MI)

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Spouse Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

**PART III – PATIENT DATA:** Claim is for:    Self    Spouse    Dependent Child    Other

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(First Name) (Last Name) (MI)

If claim is for dependent child, indicate relationship:    Child    Step Child    Legal Guardianship    Other \_\_\_\_\_

If child is age 26 or older, is child developmentally disabled or handicapped?    Yes    No   If yes contact Claims Office for instructions.

**PART IV – OTHER INSURANCE INFORMATION:**

Does patient have other health insurance coverage?    Yes    No   If yes:    Medical    Dental    Vision    Prescription

Date other coverage began? \_\_\_\_\_ Date coverage will terminate? \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_

Other Insurance company or plan administrator's name, address, telephone #, policy/plan #:

**PART V – CLAIM INFORMATION (complete only applicable information):**

Are expenses related to an injury?    Yes    No

If yes, indicate date of injury \_\_\_\_/\_\_\_\_/\_\_\_\_ and type of injury:    Automobile    Home/Recreational

Employment-Related: Name, address & telephone of employer: \_\_\_\_\_

Other \_\_\_\_\_

Briefly describe injury: \_\_\_\_\_

*Note: If claim is related to an injury, you will receive an "accident questionnaire". Respond promptly to expedite claim processing.*

**PART VI – AUTHORIZATION TO PROCESS CLAIM:**

In order to process a claim for benefits, I authorize any physician, hospital or other healthcare provider to release to Welfare & Pension Administration Service, Inc. (WPAS) and Trust, or their representatives, any information regarding my and/or my dependent's health history, symptoms, treatment, examination results or diagnosis. This authorization shall be considered valid for the duration of the claim. **It is unlawful to knowingly provide false, incomplete or misleading facts or information for the purpose of defrauding or attempting to defraud the Trust. Penalties may include imprisonment, fines, denial of insurance, and/or civil damages.**

I authorize benefit payment to the health provider for the services and/or supplies described on this claim form.    Yes    No

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## CLAIM FILING TIPS

WE WANT YOUR CLAIMS TO BE PAID ACCURATELY AND TIMELY. USING THE FOLLOWING TIPS WILL HELP US GIVE YOU BETTER SERVICE.

- Answer all of the appropriate questions and sign the claim form.
- Always send your claim form and an itemized statement of charges which includes:
  1. Employee name
  2. Patient name
  3. Provider name & Provider Tax ID number
  4. Dates of service
  5. Diagnosis (preferably with code number)
  6. Types of service (preferably with code number)
  7. Charges for each type of service
- Never send a “balance due statement” to the Claims Office.
- Complete a separate form for each patient.
- If you have other Group Insurance or Medicare as your primary coverage you must submit the itemized bill AND a copy of the matching Medicare or other insurance payment explanation.

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**15 82<sup>nd</sup> Drive, Suite 110  
Gladstone OR 97027**

**Claims Customer Service Call:  
(503) 657-9740 or (866) 697-5750**

**[www.agc-iuoe701trusts.com](http://www.agc-iuoe701trusts.com)**