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 82nd 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) (M I)

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) (M I)

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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Claims Customer Service Call:
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