ATTENDING PHYSICIAN FORM CAREFIRST BC/BS PPO GROUP #W29L

OPERATING ENGINEERS LOCAL No. 99 BENEFIT FUND

If seen by an BlueCross PPO Provider:
Send all claims to:
CAREFIRST BC/BS PPO
P.O. Box 9784
Towson, MD 21284
INFO. 1-800-235-5160

If seen by a Non-PPO Provider:
Send all claims to:
5901 Harford Road - Suite C
Baltimore, MD 21214
Info: 410-254-9595 / 1-800-367-7848

STATEMENT OF CLAIM TO BE SUBMITTED WITHIN 1 YEAR OF SERVICE

TO BE COMPLETED BY MEMBER.

1. Print your name ______________________ S.S. # A52 ______
2. If claim is for dependent -- state name of dependent ______________ Relationship of dep. ______ age of dep. ______
3. Home Address ______________________
4. Nature of Disability ______________________
5. If disability due to accident or injury, describe HOW, WHEN and WHERE it happened ______________________

The above answers are true and complete to the best of my knowledge and belief.

Signature ______________________ Date ______

TO BE COMPLETED BY ATTENDING PHYSICIAN.

1. Patient's name ______________________ age ______
2. Date first examined ______________ Where ______________
3. Diagnosis ______________________ ICD 9 Code ______

Date of Service	CPT Code	Place of Service*	Description	Unit / Days	Charge	Office Use
*Service Codes – (O) - Office (IP) - Inpatient Hospital (OP) - Outpatient Hospital (OL) - Other Location				TOTAL		

Provider Tax I.D. No. ______________ Physician Signature ______________ Date ______

Provider Name (Please Print) ______________ Address ______________

Telephone ______________

Claimant's Assignment (Read before signing)

To be completed and signed by the member if direct payment by Fund to surgeon or physician is desired. (This assignment may not be honored if signed by a dependent or person other than the claimant.) Proof of payment is required if member is to be reimbursed for $100 or more.

Date ______________

I hereby authorize the Operating Engineers Local No. 99 Benefit Fund to pay directly to Dr. ______________ (Print Name of Doctor) the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Group Policy and Certificate to the extent of his interest as established herein.

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(Signature of Insured Member)

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