Laborers Metropolitan Detroit Health Care Fund

6525 Centurion Drive / Lansing, MI 48917-9275
Toll Free Telephone 1-800-228-0048 (in Michigan)
Telephone AC 517-321-7502 (out of Michigan)

OUT-OF-HOSPITAL BENEFIT CLAIM FORM

(If claim is for In-Hospital charges or for Surgery, please complete regular claim form)

PLACE ALL BILLS/RECEIPTS IN POCKET

Participant's Name _____ Social Security Number _____

Home Address _____
Street City State Zip Code

Local Union No._____ Telephone Number _____ Date of Birth_____

Enclosed claims are for (check only one) ☐ Self ☐ Spouse ☐ Son ☐ Daughter

Dependent's Name _____ Date of Birth_____

Is dependent covered by another health insurance plan? ☐ Yes ☐ No

Type of service claims are being filed for: (circle appropriate services)

90100 Home Health Care	22222 Prescriptions	90000 Office Calls	80000 Diagnostic Lab Work	70000 Diagnostic X-rays
90500 Emergency Room	90600 Physician's Charges	01999 Acupuncture	97000 Therapy	90800 Psychiatric Care
97260 Chiropractic Care	99082 Ambulance Service	90700 Immunizations	90750 Adult Physical Exam	90755 Well Baby/Child Care
96500 Cancer Therapy	94650 Oxygen	99002 Prosthetic Devices	95120 Allergy Injections/serum	33333 Durable Equipment

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Are claims related to an illness? ☐ Yes ☐ No If "Yes" describe _____

_____

Are claims related to an injury/accident? ☐ Yes ☐ No If "Yes" describe _____

_____

Is claim the result of a vehicular related accident? ☐ Yes ☐ No If "Yes" file claim with automobile carrier.

Is claim the result of any employment? ☐ Yes ☐ No If "Yes" file claim with workers' compensation carrier.

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentional falsify any of the above information the claim involved may be denied. I authorize the release, when requested by the Laborers' Metropolitan Detroit Health Care Fund, of any facts concerning the injury, illness or treatment of myself or my dependents. A photocopy of this authorization shall be considered as valid as the original. I understand that all benefits payable are considered automatically assigned and each payable benefits will be paid directly to the purveyor of service unless a paid receipt accompanies the itemized statement when submitted to the Laborers' Metropolitan Detroit Health Care Fund for payment.

If claim is for spouse, spouse must also sign.

_____	_____	_____
Spouse's Signature	Date	Participant's Signature

USE ONE CLAIM ENVELOPE FOR EACH FAMILY MEMBER

Return Address

_____

_____

_____

PLACE
STAMP
HERE