EDI PAYER ID # 94177
P.O. Box 2500
San Francisco, CA 94126
Inquiries: 415/986-6276 or
888/877-8363

INSTRUCTIONS FOR FILING CLAIM: Use a separate form for each family member. Attach itemized bills and return to address above.

TO BE COMPLETED BY COVERED EMPLOYEE

Employee Name: Last	First	M.I.	Marital Status	Soc. Sec. #	Date of Birth

Address: Street	Apt. #	City	State	ZIP

Group Name/Employer

CLAIM IS FOR (check one): ☐ **self** ☐ **dependent**. If claim is for dependent, please complete information below.

Dependent's Name: Last	First	M.I.	Marital Status	Relationship	Date of Birth

CLAIM INFORMATION

Describe Sickness/Accident Suffered

Date Sickness Began/Date of Accident	Was the accident or sickness work related? ☐ Yes ☐ No
Is your spouse or any of your other dependents employed?	☐ Yes ☐ No If yes, please complete the information below.

Dependent's Name	Relationship	Name and Address of Employer	Spouse's Date of Birth

Are you or your spouse or any child covered under Medicare?	☐ Yes ☐ No
Are any hospital, surgical or medical benefits or services provided under any group, blanket, school, franchise or "No Fault" auto insurance plan, or under any state, federal or other governmental program?	☐ Yes ☐ No If yes, please provide name and address of the insurance company or other organization providing benefits and the policy number.

Name	Address	Policy #

AUTHORIZATION TO RELEASE CLAIM INFORMATION TO ALLIED ADMINISTRATORS, INC.

To Any: Physician, hospital, pharmacist or other provider of health care services; insurer, employer, group policyholder, government agency; consumer reporting agency; acquaintance; policy or benefit plan administrator:

You may give Allied Administrators, Inc., information about ________________________________ health, work status or health coverage.
(Claimant's Name)

You may also give this information on Allied Administrators' behalf to: (a) the claim investigation department of a consumer reporting agency; or (b) the claim department of a policy or benefit plan administrator. Health information means all information about: (a) a physical or mental health condition; (b) medical treatment and supplies; and (c) drug or alcohol use if needed to evaluate my claim. This information will be used to evaluate my claim for benefits. Benefits are self-funded by the Health & Welfare Trust Fund in which I participate. This form will be valid for the duration of my claim. A photocopy of this form is as valid as the original. I will receive a copy of this form if I ask for one in writing.
For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

____ ______________________
Signature of Claimant (if not a minor) Date

____ ______________________
Signature of Covered Employee Date

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