Plumbers & Steamfitters
Local #267
Insurance Fund

HOW TO REQUEST BENEFITS

1. COMPLETE ITEMS 1 THROUGH 10 UNDER THE PATIENT INFORMATION SECTION. IF YOU ARE MARRIED, OR HAVE OTHER HEALTH BENEFITS, ITEMS 12,13,14, AND 15 MUST BE COMPLETED. IF ANY INFORMATION IS MISSING, IT WILL DELAY THE PAYMENT OF YOUR CLAIM.
2. HAVE YOUR DOCTOR COMPLETE THE PHYSICIAN'S INFORMATION SECTION, OR SUBMIT COMPLETELY ITEMIZED BILLS. AN ITEMIZED BILL MUST CONTAIN: PATIENT'S NAME, RELATIONSHIP, DATE OF SERVICE, TYPE OF SERVICE RENDERED, NATURE OF CONDITION BEING TREATED. IF THIS INFORMATION IS MISSING, YOU MAY WRITE IT ON THE BILL, AND SIGN YOUR NAME. IF YOU GO TO A NON-PARTICIPATING PHARMACY OR DO NOT USE YOUR PRESCRIPTION DRUG CARD, COMPLETE A SEPARATE PRESCRIPTION DRUG CLAIM FORM.
3. IF YOU WANT BENEFITS PAID TO YOUR DOCTOR, OR PROVIDER DIRECTLY, BE SURE TO SIGN ITEM 17.
4. COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER.
5. THE COMPLETED CLAIM FORM SHOULD BE RETURNED TO:

POMCO
P.O. BOX 6329
SYRACUSE, NY 13217

TOLL FREE NUMBER 1-800-967-5564

IMPORTANT REMINDER:
PLEASE BE SURE THE EMPLOYEE'S SOCIAL SECURITY NUMBER HAS BEEN PROVIDED.

POMCO®

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACTUAL MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME"

PLAN ADMINISTERED BY

POMCO

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SYRACUSE, NY 13217
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MEDICAL/SURGICAL/MAJOR MEDICAL BENEFIT REQUEST FORM

EMPLOYEE

PATIENT INFORMATION SECTION

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE SELF / SPOUSE / CHILD / OTHER	3. SEX M / F	4. PATIENTS DATE OF BIRTH MONTH / DAY / YEAR

5. IF FULL TIME STUDENT GIVE NAME AND ADDRESS OF SCHOOL AND YEAR OF GRADUATION

6. EMPLOYEE NAME FIRST / MIDDLE / LAST	7. EMPLOYEE SOCIAL SECURITY NUMBER
	- -

8. EMPLOYEE MAILING ADDRESS	EMPLOYEE'S BIRTH DATE	9. EMPLOYER **Plumbers & Steamfitters Local #267** Plan 890
CITY, STATE, ZIP		10. IS TREATMENT A RESULT OF AN AUTO ACCIDENT? ☐NO ☐YES IF YES, GIVE DESCRIPTION AND DATE.

11. IS THE TREATMENT A RESULT OF AN ACCIDENT? ☐YES ☐ NO IF YES PLEASE DESCRIBE. HOW, WHEN AND WHERE? IS TREATMENT DUE TO A WORK - RELATED CONDITION? ☐YES ☐NO

12. IS YOUR SPOUSE EMPLOYED? SPOUSE'S NAME ☐YES ☐NO	SPOUSE'S BIRTH DATE	SPOUSE'S SOCIAL SECURITY NUMBER
		- -

13. NAME, ADDRESS AND PHONE NUMBER OF SPOUSE'S EMPLOYER

14. IS THE PATIENT, YOUR SPOUSE, YOURSELF, OR ANY OTHER FAMILY MEMBER COVERED BY ANOTHER HEALTH BENEFIT PLAN? ☐YES ☐NO IF YES, ANSWER QUESTION 15. NAME OF FAMILY MEMBER COVERED

15. HEALTH PLAN NAME GROUP NUMBER NAME AND ADDRESS OF OTHER HEALTH INSURANCE COMPANY

16. I CERTIFY THE INFORMATION GIVEN BY ME IS COMPLETE AND CORRECT, AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE PATIENT NAMED. I AUTHORIZE ANY PHYSICIAN OR HOSPITAL TO PROVIDE PERTINENT RECORDS TO POMCO UPON REQUEST TO ESTABLISH MY CLAIM FOR BENEFITS UNDER THIS PLAN.

SIGNATURE OF COVERED EMPLOYEE DATE

17. I AUTHORIZE POMCO TO PAY ANY BENEFITS DUE TO THE PROVIDER I HAVE INDICATED.

SIGNED (EMPLOYEE) DATE PLEASE PAY DR.

PHYSICIAN

PHYSICIAN OR PROVIDER INFORMATION (SEE REVERSE FOR INSTRUCTIONS)

18. ONSET OF INJURY OR ILLNESS	19. DATE FIRST CONSULTED BY YOU FOR THIS CONDITION	20. IF EMERGENCY ILLNESS OR INJURY, BRIEFLY DESCRIBE.

PLACE OF SERVICES CODES
H - HOSPITAL O - OFFICE VISITS L - LAB
OP - OUTPATIENT X - OTHER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

DATE OF SERVICE	PLACE OF SERVICE CODE	DIAGNOSTIC CODE (ICD,DSM)	PROCEDURE CODE (CPT - 4)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	FEE

PROVIDER NAME AND ADDRESS	TOTAL FEE CHARGED	
	AMOUNT PAID	
CITY, STATE, ZIP TAXPAYER IDENTIFICATION NUMBER	BALANCE DUE	

I HEREBY CERTIFY THAT THE PROCEDURES INDICATED BY DATE HAVE BEEN COMPLETED.

DOCTOR'S SIGNATURE _____ DATE _____

PHONE NUMBER _____