P-PLAN CLAIM FORM

BAKERY AND CONFECTIONERY UNION AND INDUSTRY INTERNATIONAL HEALTH BENEFITS FUND

10401 CONNECTICUT AVENUE, KENSINGTON, MARYLAND 20895-3960

PATIENT AND PARTICIPANT INFORMATION (PARTICIPANTS MUST SUPPLY SOCIAL SECURITY NUMBER)

1. PATIENT'S NAME (*First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. PARTICIPANT'S NAME (*First name, middle initial, last name)*

PARTICIPANT'S MARITAL STATUS ☐ Married ☐ Divorced ☐ Unmarried

4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*

TELEPHONE NO.

5. PATIENT'S SEX

MALE ☐ ☐ FEMALE

6. PARTICIPANT'S SOCIAL SECURITY NUMBER

7. PATIENT'S RELATIONSHIP TO INSURED

SELF	SPOUSE	CHILD	OTHER
☐	☐	☐	☐

8. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

9. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I Authorize the Release of any Medical Information Necessary to Process this Claim.

SIGNED: _____ DATE: _____

10. COVERED MEDICAL EXPENSES – See reverse side for explanation.

A. MEDICAL EXPENSES – Please describe type of expense, list date of service and reimbursement amount and attach proof of payment to claim form. There is additional space on the reverse side.

TYPE OF EXPENSE (Medical, Dental, Prescription Co-Pay, Deductible)	DATE OF SERVICE	REIMBURSEMENT AMOUNT

B. PREMIUM REIMBURSEMENT – Please provide type of premium, i.e. COBRA, W-Plan, Medicare Part B, or any other medical coverage; the period covered and reimbursement amount. You must attach proof of payment.

TYPE OF PREMIUM	PERIOD COVERED	REIMBURSEMENT AMOUNT

C. DEATH BENEFIT – Please provide beneficiary's name, address and attach death certificate. There is additional space on the reverse side.

NAME	ADDRESS

11. I AUTHORIZE PAYMENT OF REIMBURSEMENT AMOUNTS SHOWN ABOVE AND ON REVERSE SIDE, IF APPLICABLE, FROM MY P-PLAN BENEFITS.

SELECT ONLY ONE FORM OF PAYMENT:

☐ I AUTHORIZE PAYMENTS DIRECTLY TO MYSELF OR ☐ I AUTHORIZE PAYMENTS TO THE PHYSICIAN OR SUPPLIER REFLECTED ON THE ATTACHED PROOF OF CLAIM

SIGNED (PARTICIPANT): _____ DATE: _____

P-PLAN'S DEFINITION OF COVERED MEDICAL EXPENSES

Covered Medical Expenses are those amounts described by subsections (a) through (i) that the Participant or a Dependent is obligated to pay, and that are not paid by Medicare or by any other plan or policy of medical coverage or medical insurance. Covered Medical Expenses include deductible or coinsurance amounts and amounts that exceed applicable benefit caps or allowable charges under any other plan, policy or program.

a) Services and supplies provided by a hospital, outpatient surgical facility, nursing or convalescent home, rehabilitation facility, or alcohol, drug or psychiatric treatment facility, and that are necessary for the diagnosis or treatment of any illness of or injury to the mind or body.

b) Services, equipment and supplies provided, prescribed, or ordered by a physician or other licensed health-care practitioner within the scope of the license, and that are necessary for the diagnosis or treatment of any illness of or injury to the body or the mind.

c) Nursing care that can be provided only by a Licensed Practical Nurse (LPN) or Registered Nurse (RN).

d) Services and supplies provided by a dentist for the diagnosis, treatment, reconstruction, or professional care of the teeth, gums and tissues of the mouth.

e) Eye examinations, corrective lenses and frames.

f) Medicines that may legally be dispensed only by prescription, insulin, and prescriptions that must be compounded by a pharmacist.

g) Hearing aids.

h) Physicals, other routine examinations, and preventive vaccinations.

i) Rental charges for durable medical equipment, such as wheelchairs, equipment for the administration of oxygen, or hospital beds. (Benefits may be paid for the purchase of such equipment if the purchase price is lower than the projected cost of rental.)

Covered Medical Expenses do not include services, equipment, or supplies that are prescribed or ordered by a physician or other licensed provider solely for personal hygiene, beautification, comfort or convenience, or for custodial care that does not require the education, training or technical skills of an RN or LPN.

ADDITIONAL COVERED MEDICAL EXPENSES

TYPE OF EXPENSE/PREMIUM	DATE OF SERVICE/PERIOD COVERED	REIMBURSEMENT AMOUNT

ADDITIONAL BENEFICIARIES

NAME	ADDRESS