TRANSPORTATION - COMMUNICATION - INTERNATIONAL UNION
LOS ANGELES METROPOLITAN TRANSPORTATION AUTHORITY
HEALTH AND WELFARE TRUST FUND
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5090 •(800) 427-5342

MAIL ALL CLAIMS TO:
T.C.U.-L.A.M.T.A.
Health and Welfare Fund

Medical

MEDICAL STATEMENT OF CLAIM

1. Employee must submit one fully-completed claim form per patient. All questions in Employee Data and Patient Data sections whether claim is employee, retired employee, spouse, or dependent child MUST be completed.
2. Your completed medical claim form must be submitted along with the itemized bill from your doctor, hospital, and/or pharmacy for reimbursement. Itemized bills MUST include: Patient's name, diagnosis, date of service and charge.
3. If patient is covered by Medicare, submit BOTH an itemized billing and the Explanation of Benefits from Medicare. Without BOTH, your claim will be delayed.
4. Please DO NOT send any bills unless they are attached to a completed claim form.
5. Send completed claim form and related itemized medical bills to claim office address shown above.

I. EMPLOYEE DATA

1. Name (First, Middle & Last)	2. Sex ☐ M ☐ F	3. Date of Birth	4. Social Security Number
5. Home Address Street			7. Employee Status: ☐ Full Time ☐ Leave of Absence ☐ Part time ☐ Layoff ☐ Retired ☐ COBRA Continuant
City State Zip	6. Last date employee worked before charges for this claim began		

II. PATIENT DATA

8. Patient Name (First, Middle & Last)	9. Birthdate	10. Sex ☐ M ☐ F	11. Relationship ☐ Self ☐ Spouse ☐ Child ☐ Incapacitated Dependent ☐ COBRA Continuant

12. Are natural Parents Divorced or Separated? ☐ Yes ☐ No	13. Do you have custody of the child? ☐ Yes ☐ No	14. Does Natural Parent WITHOUT custody have Financial responsibility for health expenses? ☐ Yes ☐ No	15. Was this parent covered by another Group Medical or Medicare or other governmental plan at the time charges were incurred? ☐ Yes ☐ No

16. Reason for Claim	17. If accident – Please provide date, place and how it happened		
	Date	Place	How it happened
18. Was illness or accident work related? ☐ Yes ☐ No			

III. SPOUSE DATA (Must be completed if claim is for spouse or child)

19. Spouse Name (First, Middle & Last)	20. Spouse's Social Security Number	21. Spouse's Date of Birth
22. Spouse's Employer Name	23. Spouse's Employer Address	24. Spouse's Employer Area Code & Phone No. ( )

IV. OTHER INSURANCE DATA (Must be completed if question 15 was answered "Yes")

25. Name of Other Insurance Company	26. Social Security Number	27. Name of Company this Person Works For

V. AUTHORIZATION TO RELEASE INFORMATION -CERTIFICATION OF ACCURACY

Upon presentation of the original or a photocopy of this signed authorization, I authorize any Physician, Medical Practitioner, Hospital, Clinic, other medical or medically related facility, insurance or reinsurance company, medical information bureau, consumer reporting agency employer, or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and or treatment of me or my dependents and any other non-medical information of me or my dependents to give to my employer, third party administrator or its plan administrator or its legal representatives, any and all such information.

I understand that information obtained under this authorization shall be used to determine my eligibility for coverage and benefits and that such information may be released to persons or organization and that it will only be valid for 30 months.

Employee Signature Date	Patient's Signature (Parent if minor) Date

DO NOT WRITE IN SPACE BELOW

Control No.	Acct No.	Plan Name	Verified By
		T.C.U.- L.A.M.T.A.	