MASTERS, MATES AND PILOTS PLANS

700 MARITIME BOULEVARD, SUITE A
LINTHICUM HEIGHTS, MD 21090-1996

ADMINISTRATOR
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STATEMENT OF CLAIM FOR ANNUAL HEALTH EXAMINATION AND IMMUNIZATION

IMPORTANT To insure payment of benefits, this form should be fully completed and submitted to the Plan Office together with original bills.

AN ANNUAL PHYSICAL EXAMINATION IS DEFINED AS A COMPREHENSIVE EXAMINATION BY A PHYSICIAN FOR A COVERED INDIVIDUAL FOR WHOM NO SPECIFIC DIAGNOSIS OR SYMPTOMS PRECIPITATED THE EXAMINATION. IMMUNIZATIONS RECOMMENDED OR ORDERED BY A PHYSICIAN ARE COVERED UNDER THIS BENEFIT.

PART I. TO BE COMPLETED BY ELIGIBLE PARTICIPANT CLAIMING BENEFIT FOR SELF OR ELIGIBLE DEPENDENT

1. Print Name of Employee _____ Employee Social Security No. _____

2. Sex _____ Date of Birth ___/___/___ Single ☐ Married ☐ Active ☐ Pensioner ☐ Membership Group _____

3. Home Address: _____
Number and Street City State Zip Code

4. Claim for: (check one) ☐ Self ☐ Dependent _____
Name Of Patient Relationship D.O.B. Social Security No.

If claim is for dependent, does he/she live with you? ☐ Yes ☐ No

5. Employer _____ From _____ To _____
Employment Dates

PART II. GROUP COVERAGE/ OTHER INSURANCE INFORMATION

1. Is Patient covered by Medicare? ☐ Yes ☐ **No If Yes, Effective Date** _____ and enclose copy of Explanation of Medicare Benefits form and copy of Medicare card.

2. Is Patient covered by other Health Insurance? ☐ Yes ☐ No

3. If Yes, please complete following information: _____
Name and Social Security Number of Policy Holder

_____
Employer Providing Group Coverage and Address

_____ _____
Insurance Company Name and Address Policy Group Number/ Insurance ID Number

Upon notification that benefits paid me, or on my behalf, exceed the benefits payable under the MM&P Health and Benefit Plan, I agree to reimburse the **MM&P Health** and Benefit Plan to the extent of such overpayment.

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true, correct and complete. I hereby authorize any physician, any hospital or insurance company to furnish and disclose all known facts concerning this disability and coverage to the MM&P Health and Benefit Plan upon request. A copy of this authorization shall be as valid as the original.

Employee's Signature _____ Date _____

SEE PART IV ON REVERSE FOR ASSIGNMENT OF BENEFITS

PART III ATTENDING PHYSICIAN STATEMENT

Employee's Name _____ Social Security No. _____

Patient's Name _____ Date of Birth _____

Date of Examination _____

CPT Code _____

Diagnosis Code _____

Place of Service _____

Charge _____

Date _____ _____ _____
Physician's Signature

_____ Address _____
Print or Type Physician's Name Number and Street

_____
(Stamp, Seal or Letterhead Required) City State Zip Code

Physician's SSN
or Taxpayer ID # _____ Phone _____

If your bill provides all above information, your physician does not have to complete this portion of the form. Attach bill to this Form.

PART IV ASSIGNMENT

TO BE COMPLETED AND SIGNED IN THE SPACE PROVIDED BY THE EMPLOYEE FOR DIRECT PAYMENT OF BENEFITS TO THE PROVIDER

(Read carefully before Signing)

I HEREBY ASSIGN BENEFITS WHICH ARE PAYABLE AS A RESULT OF THIS CLAIM TO THE *ABOVE PHYSICIAN*. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE PHYSICIAN FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

_____ _____
Signature of Employee Date