Public Employees Local 71 Trust Fund

Claims Office, PO Box 91013, Seattle, WA 98111-9103

A Self-Funded Health Plan

☐ **Medical** ☐ **Dental Claim Form**
(Check box(es) to identify type of claim(s)

For benefit information, information regarding preferred providers, to verify eligibility, or to preauthorize a hospital admission or medical procedure, please call 1-800-446-3671 from outside the Anchorage area or 276-7611 within the Anchorage area.

Instructions: Complete this form, attach all itemized bills, send to the Claims Office at the address above, and keep a copy for your records.

Employee Information

Full Name:	Alternate I.D.# or SSN:	
Mailing Address:		
City:	State:	Zip:

Patient Information

Full Name:	☐ Member ☐ Spouse ☐ Dependent Child
If Claim is for dependent child, indicate relationship: ☐ Child ☐ Step Child ☐ Legal Guardianship ☐ Other ____________	

Other Insurance Information

Does the patient have other health insurance coverage: ☐ Yes ☐ No	
If Yes, please provide the following information for each policy/plan: Insurance Company/Plan Administrator's Name, Address, Telephone No., Policy/Plan No., and types of coverage:	
1.	☐ Medical ☐ Dental
2.	☐ Medical ☐ Dental
Is spouse employed? ☐ Yes ☐ No If yes, please provide the name, address and telephone number of employer and/or local union:	

Claim Information (Complete only applicable information)

Are expenses related to an Accident? ☐ Yes ☐ No	If Yes, Date of Accident:
Type of Accident: **(If claim is related to an accident, you will receive an accident questionnaire. Please respond promptly to expedite claim processing.)** ☐ Automobile ☐ Home/Recreational ☐ Employment Related ☐ Other ____________	
If Employment Related, please provide Name, Address, and Telephone Number of Employer:	
Briefly Describe Accident:	

Authorization to Process Claim

In order to process a claim for benefits, I authorize any physician, hospital or other medical/dental provider to release to Zenith American Solutions and the planholder, or their representatives, any information regarding my and/or my dependent's health history, symptoms, treatment, examination results or diagnosis. This authorization shall be considered valid for the duration of the claim. ***Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.***

I authorize benefit payment to the health provider for the services and or supplies described on this claim form. ☐ Yes ☐ No

Eligible Participant's Signature:	Date:

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CLAIM FILING TIPS

WE WANT YOUR CLAIMS TO BE PAID ACCURATELY AND TIMELY. USING THE FOLLOWING TIPS WILL HELP US GIVE YOU BETTER SERVICE.

DO's

- Answer all the appropriate questions and sign the claim form.
- Always send your claim form and an itemized statement of charges which includes:
  1. Employee name
  2. Patient name
  3. Provider name & Tax ID number
  4. Dates of service
  5. Diagnosis (preferably with code number)
  6. Types of service (preferably with code number)
  7. Charges for each type of service
- Try to batch your claim submissions (send several itemized bills at one time). This will help us keep costs down.
- **If you have other insurance coverage,** please remember to submit the claim to the **primary insurance plan first.** (Refer to your health benefit booklet, "Coordination of Benefits" section to determine which plan is primary). When you receive the "Explanation of Benefits" statement (EOB) back from the primary plan, submit the claim to the secondary plan by sending that plan's claim form, a copy of the bill and a copy of the primary plan's EOB (explanation of benefit statement).

  Exception: The Zenith American Solutions Claims Office will internally coordinate the processing of a claim, if both plans are paid by Zenith.
- Always pre-certify "non-emergency surgeries and/or hospital confinements" by calling 1-(800) 446-3671 outside the Anchorage area or 276-7611 within the Anchorage area.
- Have your physician submit a completed "medical pretreatment estimate form" for all claims expected to exceed $1,000 to the Zenith American Solutions Claim Office. Or have your dentist submit a "pre-treatment dental plan" for all claims expected to exceed $500 to the Zenith American Solutions Claim Office. By doing this, you will know your "out-of-pocket expenses" **before** services are rendered.

DON'Ts

- Never send a "balance forward bill" to the Zenith American Solutions Claims Office.
- Make certain you know who is going to file your claim. Do not submit a claim yourself, if your health care provider tells you they will submit the claim for you. Duplicate claim filing adds to the administrative expense of operating our plan.