

**LOSS OF TIME CLAIM FORM
MARYLAND ELECTRICAL INDUSTRY HEALTH FUND
COLLECTION AND CLAIMS OFFICE**

BCBSM
GROUP NO. 2003

9411 PHILADELPHIA ROAD, SUITE S, BALTIMORE, MD 21237-4168
410-444-8516-18 - 1-800-352-2740-41 Fax: 410-444-0035

WARNING: This claim will not be paid if not filed within 1 year, except see below for filing WEEKLY DISABILITY BENEFITS as to time limit for certification.

PATIENT & INSURED (SUBSCRIBER) INFORMATION		
PATIENT'S NAME	PATIENT'S DATE OF BIRTH	MEMBER'S SOCIAL SECURITY NUMBER:
MEMBER'S NAME & ADDRESS	PATIENT'S SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	OTHER HEALTH INSURANCE COVERAGE — Enter Name of Policyholder, Plan Name & Address and Policy/Medical Assistance No.
	Patient's Relationship to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
EMPLOYER'S NAME & ADDRESS	Was Condition Related To: A. Patient's Employment YES <input type="checkbox"/> NO <input type="checkbox"/>	LAST DAY WORKED: _____ ARE YOU RECEIVING WORKER'S COMPENSATION BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE YOU BEEN PAID ANY VACATION/SICK TIME FROM YOUR EMPLOYER DURING THIS DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
	B. An Auto Accident YES <input type="checkbox"/> NO <input type="checkbox"/>	
EMPLOYER'S TELEPHONE NUMBER: _____		
PLEASE GIVE A BRIEF STATEMENT DESCRIBING YOUR DISABILITY		WARNING: SEVERE PENALTIES ARE IMPOSED IF YOU ARE WORKING OR DRAWING WORKER'S COMPENSATION DURING THE PERIOD YOU ARE PAID DISABILITY BY THIS FUND.
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of medical benefits (not to exceed the reasonable and customary charge for those services) as supplied to me by the undersigned physician	SIGNED (MEMBER)	DATE
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any medical information acquired in the course of my examination and/or treatment necessary to process this claim.	SIGNED (PATIENT, OR PARENT, IF MINOR)	DATE

PHYSICIAN CERTIFICATION OF DISABILITY							
DISABILITY MUST BE VERIFIED BY YOUR PHYSICIAN EVERY 30 DAYS.							
ILLNESS:--Diagnosis _____							
Is disability due to an ACCIDENT? _____ Is disability due to injury or sickness arising out of patient's employment? _____							
Nature of Injury _____							
Date patient first consulted you for this illness/injury _____							
This is to certify that he/she was under my care, and was totally/partially (circle one) disabled and prevented from performing all duties of his/her occupation from _____, 20____ to and including _____, 20____.							
Estimated further duration of total disability _____ days. (Answer if patient is still disabled)							
NOTE: Claimant must be physically TOTALLY disabled and in addition be unable to work to qualify for weekly benefits. PARTIAL disability does not count.							
Additional Remarks: _____							
FEDERAL TAX I.D. NUMBER	SSN	EIN	PATIENT'S ACCOUNT NO.	ACCEPT ASSIGNMENT?	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE
	<input type="checkbox"/>	<input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)				PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & TELEPHONE NUMBER			
SIGNED _____				DATE _____			