Medical / Dental Claim Form P60

APEA – AFT Health and Welfare Trust
PO Box 34840, Seattle WA 98124-1840
Claims Customer Service Call: (800) 331-6158

Instructions:
Please complete this form, attach all itemized bills, send to the appropriate Claims Office, and keep a copy for your records.

Mail self-submitted Medical and Dental Claims to:
APEA – AFT Health and Welfare Trust, PO Box 34840
Seattle, WA 98124-1840

PART I - TYPE(S) OF CLAIM: Check type(s): □ Medical □ Dental

PART II – EMPLOYEE INFORMATION:

Employee Name:_____ Social Security or ID #_____
(First Name) (Last Name) (M I)

Mailing
Address:_____
(Street) (City) (State) (Zip)

Spouse Name:_____Social Security #_____

PART III - PATIENT DATA: Claim is for: □ Self □ Spouse □ Dependent Child

Patient Name:_____ Birth Date: _____/_____/_____
(First Name) (Last Name) (M I)
If claim is for dependent child, indicate relationship: □ Child □ Step Child □ Legal Guardianship □ Other _____

Is your child developmentally disabled or handicapped? □ Yes □ No If yes contact Claims Office for instructions.

PART IV - OTHER INSURANCE INFORMATION:

Does patient have other health insurance coverage? □ Yes □ No If yes: □ Medical □ Dental □ Vision

Date other coverage began?_____ Date coverage will terminate? _____

Subscriber Name: _____ Subscriber SS#:_____

Other Insurance company or plan administrator's name, address, telephone #, policy/plan #:

_____

PART V - CLAIM INFORMATION (complete only applicable information):

Are expenses related to an injury? □ Yes □ No
If yes, indicate date of injury ____/____/____ and type of injury: □ Automobile □ Home/Recreational

□ Employment-Related: Name, address & telephone of employer: _____

□ Other_____

Briefly describe injury:_____

Note: If claim is for an injury, you will be sent an "accident questionnaire". Please return it promptly to expedite claim processing.

PART VI – AUTHORIZATION TO PROCESS CLAIM:

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Welfare and Pension Administration Service, Inc. and the plan holder, 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. **It is unlawful to knowingly provide false, incomplete or misleading facts or information to a Group Insurance Plan for the purpose of defrauding or attempting to defraud the plan. Penalties may include imprisonment, fines, denial of insurance, and/or civil damages.**

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

_____ _____/____/____
Employee Signature Date

CLAIM FILING TIPS

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

- Answer all of 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 & Provider 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

- Never send a "balance due statement" to the Claims Office.
- Complete a separate form for each patient.
- If you have other Group Insurance or Medicare as your primary coverage you must submit the itemized bill AND a copy of the matching Medicare or other insurance payment explanation.

You may return this form to WPAS, Inc. in one of the following ways:

1. Mail to: APEA – AFT Health and Welfare Trust
   PO Box 34840
   Seattle, WA 98124-1840
2. Fax to: (206) 441-9110
   --or--
3. Email scanned document to: claimsubmission@wpas-inc.com

Claims Customer Service Call: (800) 331-6158

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