LOSS OF TIME BENEFITS

RETURN TO:

OPERATING ENGINEERS LOCAL 139
HEALTH BENEFIT FUND
N27 W23233 ROUNDY DRIVE • P.O. BOX 160
PEWAUKEE, WI 53072-0160
262-549-9190 • TOLL FREE 1-800-242-7018

INSTRUCTIONS

This form is to be completed by the participant and the physician. Complete participant's section fully. Be sure to sign participant's signature.

PARTICIPANT COMPLETES AND SIGNS THIS SECTION

Name of Participant _____ Date of Birth _____

Soc. Security No. _____ Occupation _____ Local No. _____

Home Address _____ City _____ State _____ Zip _____

Employer's Name and Address _____

If Benefit Request Is For Participant's Disability, Show Date Last Worked _____ Resumed Work _____

Nature of sickness or injury _____

Date accident occurred or sickness began _____ Date first treated _____

Name and address of Physicians consulted
(1) _____
(2) _____

If hospitalized,
Name of hospital _____ Admitted _____ (Date) Discharged _____ (Date)

If injured, how and where did accident happen? _____

Did injury occur in the course of any employment? ☐ Yes ☐ No

If your disability is ***permanent***, have you applied for disability benefits from Social Security or from Central Pension? ☐ Yes ☐ No

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

PARTICIPANT'S SIGNATURE

DATE

ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(If diagnosis code other than ICD9* used, give name):

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? Yes ☐ No ☐

PREGNANCY Yes ☐ No ☐ If Yes, approximate date pregnancy commenced. DATE

3. REPORT OF SERVICES (Or attach itemized bill) (If previous form submitted to this carrier, you need show only dates and services since last report)

DATE OF SERVICES	PLACE OF SERVICES†	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE — IF USED (If code other than CPT** used, give name)

☐

†O—Doctor's Office H—Patient's Home *ICD9—International Classification of Diseases **CPT—Current Procedural Terminology (current edition) H—Inpatient Hospital OH—Outpatient Hospital NH—Nursing Home OL—Other Locations

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION?
Yes ☐ No ☐ If "Yes" when and describe:

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
Yes ☐ No ☐

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (Unable to work).
From Thru

9. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:

10. DOES PATIENT HAVE OTHER HEALTH COVERAGE?
Yes ☐ No ☐ If "Yes" please identify.

PHYSICIAN'S EIN # _____

DATE	PHYSICIAN'S NAME (Print)	SIGNATURE	DEGREE	TELEPHONE

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE