

SCREEN ACTORS GUILD — PRODUCERS HEALTH PLAN

P.O. BOX 7830 • BURBANK, CA 91510-7830 • (818) 954-9400
(800) 777-4013 (Except Los Angeles Area)

INSTRUCTIONS FOR FILING A CLAIM

OTHER HEALTH INSURANCE THAT IS PRIMARY:

Submit your bills to your other Health Insurance Carrier first. When you receive their payment sheet (Explanation of Benefits or EOB), attach a copy to this claim form and follow instructions 1 through 5 below for filing a claim.

- 1. COMPLETE PART 1 OF THIS FORM: This form is required for each member of the family for each separate accident or illness.
2. SIGN THE FORM: The Eligible Participant must sign this form. In addition, the spouse's signature is required if the claim is for the spouse.
3. ASSIGNMENT OF BENEFITS (OPTIONAL): Please complete Part 3 on the reverse side of this form if you desire direct payment of benefits to your provider (hospital, doctor, etc).

- 4. ATTENDING PHYSICIAN'S STATEMENT: Have your Doctor complete Part 2 on the reverse side of this form, OR Attach your itemized bills to this claim form.
5. MAIL TO: Claims Department, Screen Actors Guild—Producers Health Plan, P.O. Box 7830, Burbank, CA 91510-7830

THIS PART 1 MUST BE COMPLETED IN FULL AND SIGNED BY THE ELIGIBLE PARTICIPANT. FAILURE TO COMPLETE ANY OF THE ITEMS BELOW WILL DELAY SETTLEMENT OF YOUR CLAIM.

PART I

1. PARTICIPANT [Social Security Number boxes]

Name & Address, New address? [Yes/No], HOME PHONE, WORK PHONE

Circle One: Legally Single Married Separated Divorced Widowed

2. SPOUSE [Spouse Social Security Number boxes]

Name, Employer, Is spouse a member of SAG? [Yes/No]

3. PATIENT [Self/Spouse/Child/Stepchild], Name

Birthdate, Sex: [Male/Female]

Is dependent child a member of SAG? [Yes/No], Dependent SS#

4. IS PATIENT COVERED BY MEDICARE? [YES/NO]

5. DO YOU OR OTHER FAMILY MEMBERS HAVE MEDICAL HEALTH INSURANCE OTHER THAN THIS PLAN? [YES/NO]

Name of insured, Relationship, Soc. Sec. No., Name, Claim filing address & phone number of other insurance

Policy No. of other insurance, Name (Employer), Employer's Telephone No., Is insured retired with above employer? [Yes/No]

6. WHAT IS THE REASON THE PATIENT IS SEEKING MEDICAL ATTENTION?

7. IS THIS CLAIM DUE TO AN ACCIDENT? [YES/NO]

Date of Accident/Injury, Location, How occurred

8. WAS ILLNESS OR INJURY CAUSED BY YOUR JOB? [YES/NO]

If Yes, complete below: Date, Time, Employer

Have you/your dependent filed a claim for workers' compensation benefits? [Yes/No]

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, medical practitioners, hospitals, pharmacies, or other institutions rendering care and treatment to furnish the Screen Actors Guild - Producers Health Plan with full information regarding the care and treatment rendered (including copies of their records). I/We also authorize any Union, Trust Fund, Employer, or Insurance Carrier to furnish the Screen Actors Guild - Producers Health Plan with information regarding benefits to which I/We may be entitled. A copy or photocopy of this authorization to furnish information shall be as valid as the original. I/We agree to reimburse the Screen Actors Guild - Producers Health Plan to the extent of any overpayment in excess of Plan benefits due.

I/We hereby authorize the Screen Actors Guild - Producers Health Plan to furnish to an agent, designee, or representative, any and all records pertaining to medical history, services rendered, or treatment given for purposes of review, investigation or evaluation of the processing of any claim or for any other purpose reasonably related to same. This authorization shall become effective immediately and shall remain in effect as long as necessary to fulfill the obligations required by the activities undertaken.

Date, Spouse's Signature (Required, if claim is for spouse), Eligible Participant's Signature

Any person who knowingly and with intent to injure, defraud or deceive, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

HEALTH INSURANCE CLAIM FORM

PART 2 ATTENDING PHYSICIAN'S STATEMENT

TYPE OR PRINT MEDICARE MEDICAID CHAMPUS OTHER

PATIENT & INSURED (SUBSCRIBER) INFORMATION		
PATIENT'S NAME (First name, middle initial, last name)	PATIENT'S DATE OF BIRTH	INSURED'S NAME (First name, middle initial, last name)
PATIENT'S ADDRESS (Street, city, state, ZIP code)	PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	INSURED'S SOCIAL SECURITY NO.
	PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	INSURED'S GROUP NO. (Or Group Name)
OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	MEMBER'S ADDRESS

PHYSICIAN OR SUPPLIER INFORMATION			
DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE FIRST CONSULTED YOU FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
DATE PATIENT ABLE TO RETURN TO WORK	DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		
NAME OF REFERRING PHYSICIAN		FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES:	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1. _____

2. _____

3. _____

4. _____

A	B	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D	E	F	
DATE OF SERVICE	PLACE OF SERVICE	PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	DIAGNOSIS CODE	CHARGES		
					TOTAL CHARGE	AMOUNT PAID	BALANCE DUE

SIGNATURE OF PHYSICIAN OR SUPPLIER	YOUR SOCIAL SECURITY NO.	HAS CONSULTATION(S) BEEN PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COPY OF CONSULTATION REPORT(S) REQUIRED.
		PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
SIGNED _____ DATE _____	YOUR EMPLOYER I.D. NO.	I.D. NO.

IF YOU ALREADY PAID FOR SERVICES RENDERED, DO NOT COMPLETE PART 3

PART 3

EMPLOYEE'S ASSIGNMENT

(Read before signing)

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE IF **DIRECT PAYMENT** OF BASIC BENEFITS TO HOSPITAL, SURGEON OR PHYSICIAN IS DESIRED. This assignment is valid for six months from date of signature.

I hereby assign basic: Hospital Expense Benefits to the Hospital
 Surgical Expense Benefits to the Surgeon
 Medical Expense Benefits to the Physician
 (Indicate which benefits are assigned)

indicated hereon, to the extent of their interest established herein or by statements attached.

DATED _____ . SIGNED _____ (SIGNATURE OF ELIGIBLE PARTICIPANT)