



# CHIROPRACTIC BENEFIT CLAIM

## HAWAII LABORERS' HEALTH AND WELFARE TRUST FUND

PACIFIC ADMINISTRATORS, INC.

1440 Kapiolani Blvd., Suite 800 - Honolulu, Hawaii 96814

Phone: Oahu - (808) 441-8600; Neighbor Islands Dial Direct 1 (888) 520-8078; FAX - (808) 441-8750

**NOTE: Sign and return the completed form to the address above. Members are required to pay non-participating providers in full. The Fund will then reimburse the member for the allowed amounts.**

<b>Part I - THIS SECTION IS FOR MEMBER INFORMATION ONLY - PLEASE PRINT</b>				<b>FOR OFFICE USE ONLY</b>	
Last Name	First	Middle	Social Security No.	X-Rays	_____
Street Address or P.O. Box				1st V	_____
City				2 + V	_____
State				H V	_____
Zip Code				Total:	_____
<b>COMPLETE IF CLAIM IS FOR SPOUSE</b>					
Spouse's Name				#V To Date	_____
				X-Rays To Date	_____
				Total Paid	_____
				Check No.	_____
				ELIGIBLE	DETERMINED BY:
				INELIGIBLE	_____
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned doctor to release any information acquired in the course of my examination or treatment and certify that the information contained hereon is true and correct.					
Member's Signature _____				Date Signed	____/____/20____

<b>Part II - TO BE COMPLETED BY DOCTOR AND / OR LAB IF X-RAYS REQUIRED</b>					
1. Diagnosis and Concurrent Conditions (If Diagnosis Code Other Than ICDA* Used, Give Name)					
2. Is Condition Due to Injury or Sickness Arising Out of Patient's Employment? Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. Report of Services (Or Attach Itemized Bill) (If Previous Form Submitted, You Need Show Only Dates and Services Since Last Report)					
Date of Service	Place of Services †	Description of Services Rendered	Procedure Code - If Used (If Code Other Than CPT* Used, Give Name)	Charges	
Remarks:					
<input type="checkbox"/> <b>MEDICARE - MAXIMUM REIMBURSEMENT \$75.00</b>					
<b>TOTAL CHARGES \$</b> _____					
<b>AMOUNT PAID \$</b> _____					
<b>BALANCE DUE \$</b> _____					
*ICDA - International Classification of Diseases **CPT - Current Procedural Terminology (current edition) † O - Doctor's Office                      OH - Outpatient Hospital H - Patient's Home                        NH - Nursing Home IH - Inpatient Hospital                    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 <input type="checkbox"/> No <input type="checkbox"/> (If "Yes" When and Describe)			7. Patient Still Under Your Care For This Condition? Yes <input type="checkbox"/> No <input type="checkbox"/>		
8. Patient was Continuously Totally Disabled (Unable to Work)			9. Patient Was Partially Disabled.		
From _____ Thru _____			From _____ Thru _____		
10. If Still Disabled, Date Patient Should Be Able to Return to Work.			11. Patient Was House Confined.		
From _____ Thru _____			From _____ Thru _____		
12. Does Patient Have Other Health Coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> (If "Yes" Identify)					
Date	Doctor's Name (Print)	Degree	Individual Practitioners      SS#		
Doctor's Signature	Telephone		All others - Employers I.D.#		
Street Address			State or Province		
City or Town			Zip Code		