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.

Part I - THIS SECTION IS FOR MEMBER INFORMATION ONLY - PLEASE PRINT

Last Name	First	Middle	Social Security No.
			___ ___

Street Address or P.O. Box

City	State	Zip Code

COMPLETE IF CLAIM IS FOR SPOUSE

Spouse's Name		

FOR OFFICE USE ONLY

X-Rays _____
1st V _____
2 + V _____
H V _____
Total: _____
#V To Date _____
X-Rays To Date _____

Total Paid _____
Check No. _____

ELIGIBLE
INELIGIBLE
DETERMINED BY:

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____

Part II - TO BE COMPLETED BY DOCTOR AND / OR LAB IF X-RAYS REQUIRED

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 ☐ No ☐

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:

☐ MEDICARE - MAXIMUM REIMBURSEMENT $75.00

TOTAL CHARGES $ _____

AMOUNT PAID $ _____

BALANCE DUE $ _____

*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 ☐ 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. Patient Was Partially Disabled.
From Thru

10. If Still Disabled, Date Patient Should Be Able to Return to Work.

11. Patient Was House Confined.
From Thru

12. Does Patient Have Other Health Coverage? Yes ☐ No ☐ (If "Yes" Identify)

Date Doctor's Name (Print) Degree

Doctor's Signature Telephone

Individual Practitioners SS# _____

All others - Employers I.D.# _____

Must Be Furnished Under Authority of Law

Street Address City or Town State or Province Zip Code

CLAIMS MUST BE FILED WITHIN 90 DAYS FROM DATE SERVICE RENDERED

RETURN TO ADMINISTRATIVE OFFICE