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 within 90 days from the date of service.
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	D.O.B.

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	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____

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)	Individual Practitioners SS#
Date / Doctor's Name (Print) / Degree	All others - Employers I.D.#
Doctor's Signature / Telephone	Must Be Furnished Under Authority of Law

Street Address	City or Town	State or Province	Zip Code