HAWAII LABORERS HEALTH AND WELFARE FUND

1440 Kapiolani Blvd Ste 800 Honolulu, HI 96814– Fax (808) 441-8750
PHONE (808) 441-8600-NEIGHBOR ISLANDS DIAL DIRECT 1 (888) 520-8078

MASSAGE THERAPY REIMBURSEMENT CLAIM FORM

ACTIVE PLAN – SUBSCRIBER AND SPOUSE COVERAGE ONLY

PART I: SUBSCRIBER INFORMATION				
LAST NAME	FIRST NAME	M.I.	GENDER	DATE OF BIRTH

MAILING ADDRESS (NO., STREET)	CITY	STATE	ZIP CODE

IS THIS A CHANGE OF ADDRESS?	MEMBER ID OR LAST FOUR OF SOCIAL SECURITY NUMBER	TELEPHONE NUMBER:
Yes No		

PART II: PATIENT INFORMATION: *Complete this section only if the patient is not the SUBSCRIBER*					
PATIENT'S NAME (LAST NAME)	(FIRST NAME)	(M.I.)	RELATIONSHIP TO SUBSCRIBER	DATE OF BIRTH	GENDER

OTHER COVERAGE INFORMATION: *Complete only if claim is for a spouse and/or other coverage is in effect*			
IS THE PATIENT COVERED UNDER ANOTHER HEALTH INSURANCE PLAN?	Yes No		
If yes, please provide: NAME OF HEALTH INSURANCE COMPANY	EFFECTIVE DATE OF COVERAGE	POLICY NUMBER	COVERAGE (MED, DRUG, VISION, CHIRO, MASSAGE)

If you answered Yes, and the other insurance company is primary and covers massage therapy benefits, you must submit a claim to your primary insurer first. After your primary insurance processed your claim. please send us this form and (a) a copy of the explanation of benefits (EOB) and (b) the itemized bill(s) for this claim.

PART III: TO BE COMPLETED BY MASSAGE THERAPIST OR BUSINESS – ALL SECTIONS ARE REQUIRED			
DATE OF SERVICE			
MASSAGE THERAPIST NAME			
BUSINESS NAME (IF APPLICABLE)			
LICENSE NUMBER FOR BUSINESS OR MASSAGE THERAPIST *(ex: MAE-1111, MAT-1111)*			
DESCRIPTION OF SERVICE			
BILLED CHARGE AMOUNT			
TAXES			
PAID AMOUNT			
SIGNATURE		DATE	

PART IV: REQUIRED DOCUMENTATION

When submitting your Massage Therapy Reimbursement form, please include a copy or the original receipt for the services performed. Information on the receipt should match the information described in Part III of this form for reimbursement to be considered.

CERTIFICATION

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

I certify that the information supplied is true and correct.

SUBSCRIBER'S SIGNATURE: **DATE:**

1. Mail this claim form(s) and required documentation to: **Claims Department**
   1440 Kapiolani Blvd., Ste. 800
   Honolulu, HI 96814
2. Fax this claim forms and required documentation to: **808-441-8750**

CLAIMS MUST BE FILES WITHIN 90 DAYS FROM THE DATE THE SERVICE IS RENDERED.