PWGA Pension & Health Plans
YOUR TRUSTED GUIDE

Writers' Guild-Industry Health Fund

Participant Submitted Claim Form

Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite timely and accurate processing
SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS.

Section A. PATIENT INFORMATION

Last name	First name	M.I.

Does the patient have other health insurance coverage? ☐ Yes ☐ No	Relation to participant ☐ Self ☐ Spouse ☐ Son ☐ Daughter	Sex ☐ M ☐ F	Date of birth (MM/DD/YY)

Name of other health insurance company	Group no.	Employer name	Policy no.

Section B. PARTICIPANT INFORMATION (on Writers' Guild- Industry Health Fund card)

Participant ID#	Group No.
WRXA	

Last name	First name	M.I.

Street Address (please include apt.no.)

City	State	Zip code

Home phone no.	Work phone no.	Date of birth (MM/DD/YY)	Sex
( ) -	( ) -		☐ M ☐ F

Section C. MEDICAL INFORMATION

DIAGNOSIS/ICD-10-CM code number(s) This information must be obtained from your provider and listed in priority order.

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

Was this medical expense the result of an accident? .....Y ☐ N ☐

Was this condition or injury job related? .....Y ☐ N ☐

Have you filed for Worker's Compensation? .....Y ☐ N ☐

When did this injury or accident occur? ..... ___/___/___ (MM/DD/YY)

CHARGES - Use a separate line to list each type of service and attach itemized bill(s) or a photocopy for all services. A separate form must be submitted if the rendering provider is different.

The following information must be obtained from your provider or must be included on your itemized statement from your provider.

4A. Date of service or purchase	4B. Type of provider	4C. Place of service	4D. Description of service or purchase using CPT or HCPCS codes (include modifier(s), if applicable)	4E. Number of days or units	4F. Charges
					$
					$
					$
					$
					$
					$

4G. Referring Provider's Name: (If you were referred, please provide a copy of the referral/prescription)	4H. Total charges	$
4I. Provider's Federal TIN or NPI:	4J. Total amount paid to provider	$

4K. Provider's name, address, telephone number:

_____

_____

( ) -

4L: I'm authorizing payment to go to: Patient ☐ Provider ☐
(Proof of payment is needed if applicable).

Authorizing Signature: _____

5. SIGNATURE - I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service that participated in any way in the patient's care to release to The Writers' Guild-Industry Health Fund any medical or other personal information that they deem necessary to provide service or adjudicate this claim. Authorization is also given to The Writers' Guild-Industry Health Fund to collect, use, or release any medical or personal information that they deem necessary to provide service or adjudicate a claim. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include inprisonment, fines, and denial of insurance benefits.

Signature of participant or patient: Date: / /

PARTICIPANT SUBMISSION CLAIM FORM INSTRUCTIONS:

California claims: Submit your claims to Anthem Blue Cross of CA, P.O. Box 60007, Los Angeles, CA 90060. (Routine Vision Care goes to Davis Vision, see website.)
Non-California claims: Submit your claims to your local Blue Card office. Refer to our website at **www.wgaplans.org** for the applicable submission address.
Non-Traditional claims: For wellness claims, submit your claims to Writers' Guild-Industry Health Fund 2900 W. Alameda Avenue, Suite 1100, Burbank CA 91505

SEE BACK

HOW TO USE THIS FORM

Dear Participant:

Usually, health care providers will bill us for services rendered to you and your enrolled dependents. This is the preferred procedure. You are not bothered with claim forms and we often need more details than are ordinarily provided on bills to patients.

Sometimes, a physician may not bill us or an ambulance company. For example, they may send the bill directly to you. In either instance, we have no way of knowing about your claim. This participant submitted claim form was developed to notify us of any covered health service for which we have not already been billed. Please read the following instructions about how to submit your Health Care claims.

If the patient has received benefits from any other health coverage plan held by reason of law or employment, the explanation of benefits form furnished by the other insurance company pertaining to these charges must be included with the claim. A clear photocopy of the other insurance company's explanation of benefits form is acceptable in place of the original document.

SECTION A. PATIENT INFORMATION

Use this section to identify the patient.

SECTION B. PARTICIPANT INFORMATION (on Writers' Guild-Industry Health Fund card)

Use this section to identify the participant. Some of this information may be found on your Writers' Guild-Industry Health Fund card.

SECTION C. MEDICAL INFORMATION: This section pertains to the detailed information regarding the patient's services.

DIAGNOSIS - The ICD-10 CM code number must be obtained from your service provider.

CHARGES - Please list the bills that are being included on this claim in the CHARGES section. Although itemized bills must also be submitted, your listing will enable us to process the claim more quickly and accurately.

If additional space is needed for listing the charges, please use a separate sheet of paper to list the following information:

4A. Date of service or purchase - Inclusive dates must be indicated for bills containing multiple dates of service.

4B. Type of provider - For example, hospital, nurse, physician, clinic, physical therapist, home health, vision, durable medical supplies, etc.

4C. Place of Service - For example, inpatient hospital, outpatient hospital, emergency room, provider office, ambulatory surgery center, etc.

4D. Description of service or purchase using CPT or HCPCS codes (include modifier(s), if applicable) - This must be obtained from your provider of services for each service performed or received.

4E. Number of days or units - Includes the number of days for an inpatient stay or the number of units for a service or purchased product.

4F. Charges - Bills must be itemized to show a separate charge for each service.

4G. Referring Provider's Name- If you were referred by a different provider, please provide the name and a copy of the referral/prescription.

4H. Total charges - Provide the total sum of charges where multiple services and/or purchases have been received.

4I. Provider's Federal TIN or NPI - Must be obtained from provider even if services are being reimbursed to member.

4J. Total amount paid to provider - If the bill has already been paid, please indicate the amount that has been paid.

4K. Provider's name, address, telephone number - Name of rendering provider, address and telephone number. Multiple bills from the same provider may be included on the same claim form, as long as the services and/or purchases are itemized separately.

4L. Payment goes to - If you have paid for the service, mark "Patient". Proof of payment must be indicated on the itemized bill for payment to be issued to the patient. If the provider of service did not indicate services paid in full on the itemized bill, proof of payment must be submitted, such as: a credit card statement, cancelled check or a receipt.

5. Signature: The Participant Submitted Claim Form must be signed and dated by the participant or patient.

BILLS MUST BE ITEMIZED

Attach itemized bill or photocopy with proof of payment (if applicable). Please be sure that duplicate bills are not submitted. Cancelled checks, cash register receipts and non-itemized "balance due" statements are not considered an itemized bill and will be denied upon receipt of itemized bill. Each itemized bill must include:

- Name, phone number and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Name and phone number of patient
- Date of service
- Amount charged for each service
- Diagnosis code
- Procedure code
- Tax ID

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