Medical Claim Form

Submit Claims to Carpenters' Health & Welfare:

Carpenters' Health & Welfare Trust Fund of St. Louis/Claims
1419 Hampton Ave, Ste 100
St. Louis, MO 63139
Phone: (314) 644-4802 | Toll-Free: (877) 232-3863 | Fax: (314) 678-1111

Please fill out the below information and **submit this form along with your itemized bill from your provider to the address listed above**. The itemized bill must contain your provider's information and tax ID number, date(s) of service, diagnosis(s), billed charges, description of charge(s) and procedure code(s).

A. Patient Name & I.D. Number :

Print Patient Name: Last Name, First Name, MI

Coventry Member ID Number with Suffix

Date of Birth

Relationship to Member

Sex ☐ Male ☐ Female

B. Member Name & I.D. Number :

Print Member Name: Last Name, First Name, MI

Coventry Member ID Number

C. Primary Insurance Information—*This section is only applicable if the patient has other Primary Insurance*:

Please attach a copy of the ***Explanation of Benefits*** statement from your Primary Insurance Carrier.

D. Authorization/Release of Information:

I authorize any insurance company, organization, employer, hospital physician, pharmacist or other health care provider to release any information requested with regard to this claim and the expenses reported. I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to omit facts I know are important.

Signature (*Signature of Parent/Guardian if Patient is a minor up to age 18*)

Date

Please see attached for Provider Documentation

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St. Louis, MO 63139

carpenters' benefit plans
HEALTH & RETIREMENT SERVICES

THIS SECTION IS INTENDED FOR PHYSICIANS ONLY

If a detailed statement is available, please attach and write:
See attached Provider Documentation

Provider Statement of Services Rendered					
Name and Address of Facility where services were rendered (if other than home or office)				Admit Date	Discharge Date
Diagnosis Code(s):	**1.**	**2.**	**3.**	**4.**	**5.**
Date Of Service From/To	**Place of Service**	**Procedure Code**	**Description of Service**	**Charges**	**Days or Units**
Provider Signature			**TIN**	Total Charges:	Amount Paid:
Provider Name			Phone Number		
Provider Address					