# PLUMBERS AND PIPEFITTERS LOCAL NO. 333

**6525 Centurion Drive**
**Lansing, MI 48917**
**Toll free Telephone: 866-348-9499**
**(517) 321-7502 • Fax (517) 321-7508**

## STATEMENT FOR LOSS OF TIME BENEFITS

(**Note: Participant must complete this side**
***Reverse side must be completed by your physician***)

| | | | |
|---|---|---|---|
| Name: | | Date of Birth: | |
| Address: | City: | State: | Zip: |
| Social Security # and/or BCBS ID#: | | | |
| Home Phone #: | Cell Phone #: | | |
| Name and Address of last Employer: | | | |
| Is this claim based on an accident/injury? | | Yes ☐ | No ☐ |
| Date sickness or accident/injury began: | | Date first treated: | |
| Did sickness or accident/injury occur in the course of employment? | | Yes ☐ | No ☐ |
| Where did sickness or accident/injury occur? | | | |
| How did sickness or accident/injury happen? | | | |
| If Hospitalized, Name of Hospital: | Admitted: | Discharged: | |
| Was surgery performed?<br>If yes, give date: And nature of surgery: | | Yes ☐ | No ☐ |
| Have you, or do you intend to file this claim under Workers' Compensation? | | Yes ☐ | No ☐ |
| On what date did you last work? | | | |
| Have you resumed work? | | Yes ☐ | No ☐ |
| If YES, what date: | | | |
| Are you Retired? Yes ☐ No ☐ | Are you receiving Social Security Disability?<br>Yes ☐ No ☐ | | |
| Signature: | | Date: | |

# PLUMBERS AND PIPEFITTERS LOCAL NO. 333
## ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

| | | |
|---|---|---|
| Patient's Name:<br>Member ID or SS #: | Date of Birth: | |
| Diagnosis and Concurrent Conditions:<br>ICD9/10 Code: | | |
| Is this claim based on an accident/injury? | Yes ☐ | No ☐ |
| Date sickness or accident/injury began: | Date first treated: | |
| Is condition due to injury or sickness arising out of patient's employment? | Yes ☐ | No ☐ |
| If YES, explain: | | |
| Is condition due to pregnancy?<br>If Yes, approximate date pregnancy commenced: | Yes ☐ | No ☐ |
| This patient has been continuously disabled (first day unable to work) from _____ through (last day unable to work) _____. | | |

REPORT OF SERVICES (Or attach itemized bill) (If previous form submitted to their carrier, you need show only dates and services since last report)

| DATE OF SERVICES | PLACE OF SERVICES | DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED | PROCEDURE CODE – IF USED | CHARGES |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

IO – Doctor's Office IH – Inpatient Hospital NH – Nursing Home H – Patient's Home OH – Outpatient Hospital OL – Other Locations

| | | |
|---|---|---|
| Exact date patient will be able to return to work at trade: | | |
| If exact date is unknown, please estimate: | | |
| Is patient still under your care for this condition? | Yes ☐ | No ☐ |
| If YES, give date of last treatment: | | |
| If YES, give date of next scheduled appointment: | | |
| If NO, give date treatment terminated: | | |
| Physician's Signature: | Date: | |
| Physician's Name (please print) | Degree: | |
| Address: | | |
| City: State: Zip: | | |
| Telephone Number:<br>Fax Number: | | |