CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

P.O. BOX 3010 • CONCORD, CALIFORNIA 94522 • TELEPHONE (925) 676-3828

BENEFITS PAYABLE FOR ONE EXAMINATION PER CONTRACT YEAR BEGINNING SEPTEMBER 1 THROUGH AUGUST 31

MULTIPHASIC PHYSICAL EXAMINATION CLAIM

CARPENTER'S NAME — LAST	FIRST	MIDDLE	DATE OF BIRTH MO. DAY YEAR	CARPENTER'S SOCIAL SECURITY NO.
				___ ___ ___ ___ ___ ___ ___ ___ ___

ADDRESS	STREET	CITY	STATE	ZIP CODE

PATIENT'S NAME	☐ SELF ☐ SPOUSE	DATE OF BIRTH

EMPLOYEE'S SIGNATURE (I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true and correct. **CHECK: ✓ I DO ☐ I DO NOT ☐** authorize the administrator, in his sole discretion, to pay directly to the below named physician or any other supplier of services, any benefits otherwise payable to me, but not to exceed any of the charges by the physician or other supplier of services. I understand that I am financially responsible for any charges not covered by this authorization.)

X _____ DATE _____

Did you use HEALTH EXAMINETICS for your Laboratory and/or X-Rays? Yes ☐ No ☐ If yes, give date _____
If answer is no, attach all itemized bills to this form.

CARPENTER'S STATEMENT AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I AUTHORIZE ANY MEDICAL INFORMATION RELATING TO THIS CLAIM TO BE DISCLOSED TO AND ACQUIRED BY THE ADMINISTRATOR OF THIS PLAN AND SUCH AGENTS OF THE ADMINISTRATOR AS ARE NECESSARY TO PROCESS THIS CLAIM. SUCH INFORMATION MAY BE DISCLOSED BY A HEALTH CARE PROVIDER OR OTHER PLAN ADMINISTRATOR, AND WILL BE USED FOR THE PURPOSE OF PROCESSING THIS CLAIM. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL THE CLAIM IS PAID, PROVIDED SUCH INFORMATION SHALL BE RETAINED BY THE ADMINISTRATOR IF REQUIRED BY LAW.

CARPENTER'S SIGNATURE _____ DATE SIGNED _____

TO BE COMPLETED BY PHYSICIAN

EXAMINATIONS AND PROCEDURES COMPLETED

CPT PROCEDURE NO.	PROCEDURE	DATE	FEE
99090	**Diagnostic Physical Examination.**		**$**
	PLEASE ADVISE PURPOSE OF THIS EXAMINATION:		
	☐ Multiphasic Routine Physical.		
	☐ Evaluation of Health Examinetics Multiphasic Screening results.		
	☐ Evaluation of treatment of specific complaints and/or symptoms.		
		TOTAL	**$**

Was patient referred elsewhere by you for X-Ray and/or Laboratory tests? Yes ☐ No ☐

If so, where? _____

_____

IDENTIFYING NO. (SOCIAL SECURITY NO. OR FEDERAL I.D. NO.) _____

PHYSICIAN'S NAME _____

ADDRESS _____ PHONE _____

DATE _____ PHYSICIAN'S SIGNATURE _____