



P.O. Box 1999, Studio City, California 91614-0999
818 or 310.769.0007 • FAX: 818.980.8661
www.mpiphp.org

COMPREHENSIVE MEDICAL CLAIM FORM

Rev. 4/07

SEPARATE CLAIM FORM MUST BE USED FOR EACH PATIENT
Failure to complete will delay settlement of your claim.

1. CLAIMANT (Employee/Retiree/Survivor)
Name and Address
Participant's Social Security Number Local Union, if any.
Is this a new address? Yes No
The new contact information you provide will be used to update the records maintained at both the Motion Picture Industry Pension Plan and the Motion Picture Industry Health Plan, as applicable.
2. Is patient covered by Medicare? Yes No
3. Does the patient have other Group Health Insurance besides Motion Picture Industry Health Plan (Medical) or Blue Shield (Hospital)? Yes No
Name and address of OTHER Group Insurance Company/Plan:
Phone No. Group/Policy No.
Name of Policyholder
Certificate No.
Effective Date
Name and Address of Spouse's Employer:

4. PATIENT
Name
Sex Married
M Yes
F No
5. Give reason, in your own words, for seeking medical attention. Failure to complete this item will delay settlement of your claim.
6. Was the injury involved caused by an accident? Yes No
Brief description including date, time, location and third parties involved:
7. Have you filed or will you file a claim against any third parties for the injuries involved? Yes No
8. Was the injury or illness caused or aggravated by your job? Yes No If yes: Date
Time Employer
Have you filed, or will you be filing a claim for Workers' Compensation Benefits? Yes No
9. ASSIGNMENT OF BENEFITS — I authorize payment of medical benefits directly to the physician or supplier listed on the attached form.
SIGNATURE (Participant) Do not sign if the bill has been paid by you in full
DATE

10. I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, hospitals, pharmacies, or other institutions rendering care and treatment to furnish Motion Picture Industry Health Plan with full information regarding treatment rendered (including copies of their records). I/We also authorize any union, trust fund, Employer or Insurance Carrier to furnish the Motion Picture Industry Health Plan with information regarding benefits to which I/We may be entitled. A copy or photocopy of this authorization to furnish information shall be as valid as the original.

I/We hereby authorize Motion Picture Industry Health Plan to furnish to an agent, designee, or representative, any and all records pertaining to medical history, services rendered or treatment given, for purpose of review, investigation or evaluation of the processing of any claim, or utilization review, financial audit or for any other purpose reasonably related to same. This authorization shall become effective immediately and shall remain in effect as long as necessary to fulfill the obligations required by the activities undertaken.

Participant's Signature Spouse's Signature
Date Phone

PLEASE READ CAREFULLY — Claims must be submitted within 15 months from the date of service, or 15 months from the date the primary payor paid, in coordination of benefits situations. Failure to timely file may result in the denial of your claim.

FALSE OR FRAUDULENT CLAIMS — Anyone who submits a false or fraudulent claim or information to the Plan may be subject to criminal penalties including a fine or imprisonment or both as well as damages in civil action under California and federal law. Furthermore, the Plan reserves the right to impose such restrictions upon future benefits payable to any such participant or dependent as may be necessary to protect the Plan, including deducting from said benefits the amount of any claim improperly paid.

AN ITEMIZED BILL FROM THE PROVIDER OF SERVICE MUST BE SUBMITTED WITH THIS FORM