IBEW LU #102 OTC Covid Testing Claim Form

FABIAN & BYRN, LLC

Fabian & Byrn, LLC T/P/A
IBEW Local Union # 102
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Member's Name (print in full)	**Code 9096**	Member ID# **BEW74**
Home Address	Date of Birth	Daytime Phone #
	Marital Status (circle one) Single Married Divorced Widowed	Work Status (Circle One) Active Disabled Retired Other (specify)

PATIENT INFORMATION		SPOUSE INFORMATION	
Name	Date of Birth	Name	Date of Birth
Relationship to Member Self Spouse Child Other (specify	Sex Male Female	Employer Name and Address	Employment Status Active Retired Unemployed

IF YOU OR ANY MEMBER OF YOUR FAMILY IS COVERED UNDER ANOTHER GROUP HEALTH PLAN, COMPLETE THE FOLLOWING SECTION

Covered Family Member (Circle One) Self Patient Spouse Other (specify name and relationship)	Name and address of Insurance Company		
Policy or Plan No.	Insurance I.D #	Type of coverage individual Family	

ATTESTATION

*By signing below, I confirm that these tests are for self use and not for employment or travel purposes. I further acknowledge these tests will not be sold, distributed to or used by an individual who is not a dependent or family member enrolled in the Plan. Further, I agree that, if any benefit payments are paid by the Welfare Fund for myself or my eligible dependents, and I or my dependents recover money from any person or organization accepting responsibility for these costs, I will repay the Welfare Plan for the amount of the benefit payments. My failure to cooperate with the Welfare Fund by not repaying the Plan will be reason for the Welfare Plan to withhold further Welfare Fund benefits until such monies are recouped.

Member's Signature	Date	Patient's Signature	Date

*** Please attach this claim form to proof of payment. Patient's name must be written on receipt.**

*** Signatures in highlighted areas are required for reimbursement. Please make sure form is completed.**