# Multi Union Security Trust Fund

*OPTIONS RIDER CLAIM FORM*

## A. Subscriber Information (Employee enrolled in benefits)

| Last Name | First Name | M.I. | Telephone Number ( ) |
|---|---|---|---|
| Street | City | State | Zip Code |
| Social Security Number | | | Group Number |

## B. Other Coverage (Please submit Explanation of Benefits forms along with this claim form)

| Insurance Company Name | | | |
|---|---|---|---|
| Street | City | State | Zip Code |
| Policy Holder | Relationship to Patient: ☐ Self ☐ Spouse ☐ Child | | |
| Is Patient Covered by Medicare? ☐ Yes ☐ No | Medicare ID Number | | |

## C. Patient Information

| Last Name | First Name | M.I. | |
|---|---|---|---|
| Birthdate Month Day Year | Male ☐ Female ☐ | Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child | Social Security Number |

## D. Provider Information (Physician, Supplier, or Medical Group, Etc.)

| Name | | | Telephone Number ( ) |
|---|---|---|---|
| Street | City | State | Zip Code |

I certify that the information contained on this clam form and attachments is true and correct to the best of my knowledge. I authorize the release of my medical information necessary to process this claim. I acknowledge that payment has been made in full for services submitted on this claim.

_____ _____

Patient Signature (Parent or Guardian, if patient is less than 18 years old) Date

An itemized bill with **PROOF OF PAYMENT IN FULL** must be attached. Any of the following evidence will be accepted as proof of payment:

1. An Itemized Bill indicating "Amount Paid."
2. A Patient Account Ledger with your payment noted.
3. A Cancelled Check (submit copies of both sides).
4. A Receipt in addition to the itemized bill.

Benefit payments will be made to the covered member only, not to providers.
**Assignment of Benefits will NOT be honored.**

## E. Send completed claim form and valid proof of payment via U.S. Mail or Email to:

Multi Union Security Trust
c/o PacFed Benefit Administrators
1000 N. Central Avenue, Suite 400
Glendale, CA 91202-2957
(800) 753-0222

**CLAIMS.MAIL@PACFED.COM**