



ALLIED PILOTS ASSOCIATION VOLUNTARY SUPPLEMENTAL MEDICAL AND CUSTODIAL CARE BENEFIT PLAN CLAIM FORM

Return completed form to:
WebTPA
P. O. Box 1987
Grapevine, TX 76099-1987
1-800-477-8957

**ALL CLAIMS MUST BE FILED WITHIN 1 YEAR OF DATE OF SERVICE,
NOTE: SUBMIT AN ITEMIZED STATEMENT OF EXPENSES THAT INCLUDES, NAME OF PATIENT, DATE OF SERVICE, AMOUNT OF CHARGES, ADDRESS
WHERE SERVICE WAS RECEIVED AND PROVIDERS NAME, ADDRESS, PHONE NUMBER AND TAX IDENTIFICATION NUMBER.**

SECTION A Complete this section for all claims.	Name (Last, First, Middle Initial)		Employee Number	Social Security Number	Gender	Male	Female		
	Mailing Address (<input type="checkbox"/> Check if new address)			City	State	Zip Code	Married	Single	
	Date of Birth (Month/Day/Year)	Spouse's Date of Birth (Month/Day/Year)		Date of Hire (Month/Day/Year)		American Airlines APA Staff			
	Day Telephone Number	Second Telephone Number		Status (Check one)		Active	Retired	Medical Disability	
	Have you reached your lifetime maximum benefit under AMR health coverage?			Yes	No	If Yes, has documentation been submitted?		Yes	No
SECTION B Complete this section for Dependent claims only,	Patient Name (Last, First, Middle Initial)			Patient Social Security Number					
	Patient Gender	Male	Female	Patient Date of Birth (Month/Day/Year)	Relationship to Employee	Spouse	Child/Dependent	Patient Marital Status	Married
SECTION C Complete this section for all claims.	Are you or your dependent covered or eligible for coverage under any other group health coverage, including any other group health coverage through an employer or spouse's employer? Yes No								
<i>If yes, complete the following:</i> Eligible for the following plan: Plan Name _____ Effective Date _____ Enrolled in the following plan: Plan Name _____ Effective Date _____									
PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS FOR THESE SERVICES.									
SECTION D Complete this section for all claims.	Is this patient eligible for Medicare? Yes No <i>If Yes, complete the following:</i>								
Medicare Part A (Hospital Insurance Benefits) Effective Date _____ Medicare Part B (Medical Insurance Benefits) Effective Date _____ Medicare Part D (Prescription Drug Coverage) Effective Date: _____									
PLEASE ATTACH A COPY OF THE STATEMENT OF MEDICARE CLAIM PAYMENT.									
SECTION E Complete this section for all accidents or occupational illness/injury.	Date of Accident (Month/Day/Year)	Time of Accident	AM	PM	Where did the accident occur? (City/State)		Work Related?	Yes	No
	Briefly describe the accident or occupational illness.								
SECTION F Complete this section for all claims.	ASSIGNMENT OF BENEFITS								
Do you want us to pay the provider? (Doctor, Hospital, etc.) Yes No <i>If Yes, please sign below.</i>									
<i>I hereby authorize payment of benefits otherwise payable to me up to the stated charges to the provider(s) of services for all bills included with this statement. I understand I am financially responsible for any amounts not payable or not covered by the plan.</i>									
Member Signature (DO NOT sign here if you want the payment sent to YOU.)									
SECTION G Complete this section if furloughed, TAG, a surviving spouse or a dependent child	CERTIFICATION THAT NO OTHER GROUP HEALTH COVERAGE IS AVAILABLE								
<i>I hereby certify that I have no Other Group Health Coverage ("OGHC", nor am I eligible for any OGHC, either through my employment or through my spouse's employment. Please note, Furloughed, TAG and Surviving spouse participants are not required to take the Company COBRA coverage. If you are eligible, or become eligible, for OGHC, you must take the other coverage.</i>									
_____ Signature of Furlougee, TAG, Surviving Spouse or Dependent Child age 19-26									
SECTION H Complete this section for all claims,	CERTIFICATION AND AUTHORIZATION								
<i>I certify that all the above statements are correct and complete and that the attached bill(s) represent actual services, dates and fees charged to me or my Eligible Dependents. I authorize the Plan and its agents to take any appropriate action to receive expenses paid as the result of the acts or omissions of another person. To all Physicians, Hospitals, medical service providers, pharmacists, employers and other agencies or organizations: I agree that WebTPA and their authorized representatives may see or obtain a copy of all medical, mental and dental care, drug or alcohol treatment prescribed drug, employment and insurance coverage records necessary for the proper administration of the Plan which pertains to patient. Such Information may be used to the extent deemed necessary by WebTPA to determine the value or amount payable on account of this claim.</i>									
_____ Member Signature		_____ Date		_____ Patient Signature (if different)			_____ Date		
<i>NOTE: A photocopy of the above authorization is as valid as the original.</i>									