Local 371 Amalgamated Welfare Trust Fund

290 Post Road West
P.O. Box 470
Westport, CT 06881

Phone: 203-226-4217

DURABLE MEDICAL EQUIPMENT AND SUPPLIES CLAIM FORM

MEMBER NAME: _____ SOCIAL SECURITY NUMBER _____

ADDRESS: _____ TELEPHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PROVIDER NAME: _____ TAX ID #: _____

ADDRESS: _____ TELEPHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE	DESCRIPTION	PROVIDER	CHARGE
		TOTAL CHARGES	

I authorize payment of medical benefits to the physician or supplier for services described above.

Member Signature: _____ Date: _____

I authorize the release of any medical information necessary to process this claim.

Member Signature _____ Date: _____

RECEIPTS AND LETTER OF MEDICAL NECESSITY MUST BE ATTACHED TO CLAIM FORM