Member's Name:

_____

Member's ID:

_____

Patient's Name:

_____

Additional Accident Information

WISCONSIN LABORERS' HEALTH FUND
4633 LIUNA WAY, SUITE 201 DE FOREST, WI 53532-2510
TELEPHONE: 608-842- 9101 TOLL FREE: 800-397-3373
WEBSITE: WWW.WILBENEFITS.COM

We have received a claim from the above provider. In order to properly determine benefits, we will need additional information. Please respond to the following.

1. Date of Accident: _____
2. Description of how the Accident occurred: _____
3. Location of Accident: _____
4. Was the Accident work related: _____

If Auto or Third Party Liability please include the name, address, and policy number of the Auto carrier or other liability

_____

_____

_____

I certify that the above is true and complete to the best of my knowledge. I will reimburse the Plan for any overpayment made to me or on my behalf due to error on this form.

Signature: _____ Date: _____

Thank you for your assistance.
Sincerely
WISCONSIN LABORERS' HEALTH FUND

Please Return One of the Following Ways:

Mail:
Wisconsin Laborers' Health Fund
Attn: Claims
4633 Liuna Way
Deforest, WI 53532

Fax:
(608) 846-3224
Wisconsin Laborers' Health Fund
Attn: Claims

Upload to Website:
Scan document and save to computer as PDF
Visit www.wilbenefits.com
Scroll to "upload document to claims department"
Browse for saved PDF
Upload

Email:
wlclaims@bpawi.com
Please Put "Additional Accident Information" as Subject