STATEMENT OF CLAIM

MAHONING AND TRUMBULL COUNTY BUILDING TRADES INSURANCE FUND

Mailing Address 131-33 FITCH BLVD 26 AUSTINTOWN, OH 44515

Office Location

33 FITCH BLVD

AUSTINIONN, OH 44515

(330)270-0453 1-800-435-2388

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ATTENDING PHYSICIAN'S STATEMENT THE PROMPTLY.

PATIENT'S NAME			THE SA	i de		AGE
DDRESS						
NATURE OF SICKNESS OR INJURY (desc	the complications, if any)				tark divarer	
DID THIS SICKNESS OR INJURY ARISE OU	T OF PATIENT'S EMPLOYMENT	OYES DNO				
F YEST, EXPLAIN				i ja		seed 2025 William F
B DISABILITY DUE TO PREGNANCY Q YES	O NO					
F "YES", WHAT WAS APPROXIMATE DATE	DE COMMENCEMENT OF PREGN	ANCV	1,	1.5		
NATURE OF SURGICAL OR OBSTETRICAL ERFORMED			FEE CHA	RGED		5. DATE
	DATE		ATMENT AT		BALLET, A	
GIVE DATES OF TREATMENTS AND FEES CHARGED	TREATED	HOME	HOSPITAL	OFFICE I	C.P.T. CODE	
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			TO STATE OF	Service Control		
WHAT OTHER SERVICES, IF ANY, DID YO	U PROVIDE PATIENT? (Itemize,	giving dates a	nd fees)		ula et i	
B. THE PATIENT HAS BEEN CONTINUOUSL	Y DISABLED (UNABLE TO WORK) FROM			_THROUGH	
IF STILL DISABLED, WHEN SHOULD PATIE	NT BE ABLE TO RETURN TO WO	RK?				<u> Andre Constituenti il</u> Vigi vin versio sipporti
D. REMARKS:						
(Type or Print) New Address		Toc	omply w	ith the I.R.	S. regulation	No. 301.6109-1, ali cla
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Address		goir	g to the	subscribe	f.	
City, State, Zip Phone#	are are an are a second		Social S	security No.	or	Taxpayer Identification No
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CLAIM PAYMENT AUTHORIZATION

The member hereby authorizes the Fund, at its option, to issue indemnity checks to the provider rendering services described hereon.