ALADS INSURANCE TRUST

CT SCAN BENEFIT PLAN

CLAIM FORM

We must have the following information to process your claim:

Subscriber's Name:_____

Subscriber's Employer's Name:_____ Employee Number:_____

Patient's Name:_____

Relationship to Subscriber:_____ Exam Date:_____

Provider's Name: _____

Address:_____

City:_____ State:____ Zip_____ (____)_____

Amount Due:_____

I declare the services rendered in the accompanied itemized statement were obtained solely for preventive purposes.

_____ _____

Patient's Signature Date

A receipt or billing statement verifying payment for services must accompany this claim form and mail to:

ALADS Insurance Trust
CT Scan Claim Administrator
9500 Topanga Canyon Blvd.
Chatsworth, CA 91311

To be completed by AIT CT Scan Administrator Only

ALADS / SDPOA Subscriber / Dependent ALADS Member: Y / N ABC Member: Y / N

Approved: Y / N If no, reason:_____