

DENTAL EXPENSE CLAIM FORM

Participants should complete all required information on this form. If you want to assign payment to your dentist sign authorization on reverse side.

Procedures that require prior approval are any orthodontic treatment, periodontal treatment, crowns and prosthetics (all types).

Procedures requiring pre and post operative X-rays are all of the above and extractions (all types) and root canals.

SUBMIT CLAIMS TO:

LOCAL 1158, I.B.E.W. WELFARE PLAN FUND
1149 Bloomfield Avenue, Clifton, N. J. 07012-2314

The information furnished by me on this form is true and complete according to the best of my knowledge and belief. I authorize any employer, insurance company, medical prepayment plan, service organization, physician, practitioner, or other person; any hospital, including the Veterans Administration, or other institution to release or obtain from the Local 1158 I.B.E.W. Welfare Plan Fund any medical or benefit payment information that may be required to establish the validity of this claim; and further authorize said company, person or organization, to disclose any personal or claim information required for medical case study or review. A photostat of this authorization shall be as valid as the original.

Signature of Employee (Participant) _____ (Date) _____ Signature of Spouse (If employed) _____ (Date) _____

PARTICIPANT'S STATEMENT

1. Participant's Name _____ Date of Birth _____
Social Security Number _____
If active Participant, Name of Employer _____
2. Is your spouse also employed? Yes No Name and address of spouse's employer _____

3. Is claim for Member _____ Spouse _____ Dependent _____
A. If spouse or dependent furnish name and age

Name Age

4. If dependent child is over age 18, is he/she both a full time student and dependent upon you for support and maintenance?
Yes No
If Yes, give name of school and proof of student status _____

5. Is Patient covered by any other group policy or prepayment plan? Yes No
If Yes, give name of:
Person carrying the other coverage _____
Group (employer, association, etc.) _____
Insurance Company or Plan _____
Address of Insurance Company _____
Policy or Plan No. _____

Participant's Social Security No. _____

Claim is submitted for _____ Name _____ Age _____

Pre Authorization _____
 Payment _____

NOTE: Procedures requiring prior approval
 A. Orthodontic treatment
 B. Periodontal treatment
 C. Crowns & Prosthetics (all types)

- Please attach pre-operative X-rays in all cases
- If services have been completed also attach post-operative X-rays
- If periodontal services are being claimed identify quadrant(s) involved in treatment. If less than four teeth indicate tooth numbers
- If claim is for prosthesis is this initial placement Yes ___ No ___
 If no give date of initial placement and reason for replacement

Claim No. _____

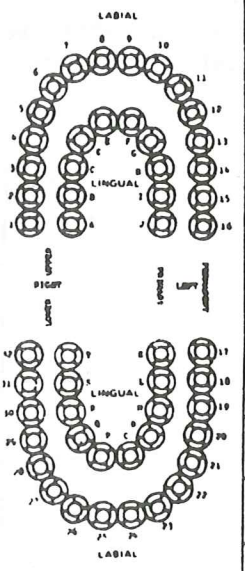
- Pre-operative X-rays attached Yes ___ No ___
- Post-operative X-rays attached Yes ___ No ___
- Periodontal charting attached Yes ___ No ___
- Other comments _____

FOR OFFICE USE ONLY

Date _____
 Reason _____

5. Furnish ADA codes for all services

DENTIST COMPLETES THIS PORTION OF CLAIM FORM

EXAMINATION AND TREATMENT RECORD								DO NOT USE
D E N T I S T	Tooth No. or Letter	Sur-faces	DESCRIPTION OF SERVICES INCLUDING X-RAY, PROPHYLAXIS MATERIALS USED ETC.	DATE SERVICE PERFORMED			ADA PROCEDURE CODE	FEE FOR EACH SERVICE
				Mo.	Day	Yr.		
 <p>ARE X-RAYS ENCLOSED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, HOW MANY? _____</p>	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							
	11							
	12							

IF MORE LINES ARE NEEDED, PLEASE USE AN ADDITIONAL CLAIM FORM(S) COMPLETING BOXES 1, 2, 3, 4 & 5 AT THE TOP OF THE FORM AND CHECK HERE

TOTAL FEES

Dentist's Name, Address & Identification No.

I hereby certify that all work claimed above has been completed

Dentist's signature

Date

I hereby authorize payment to be made directly to service provider

Participating _____ Non-Participating _____

Participant's signature

NOTE: This form must be signed by participant for assignment to be made.