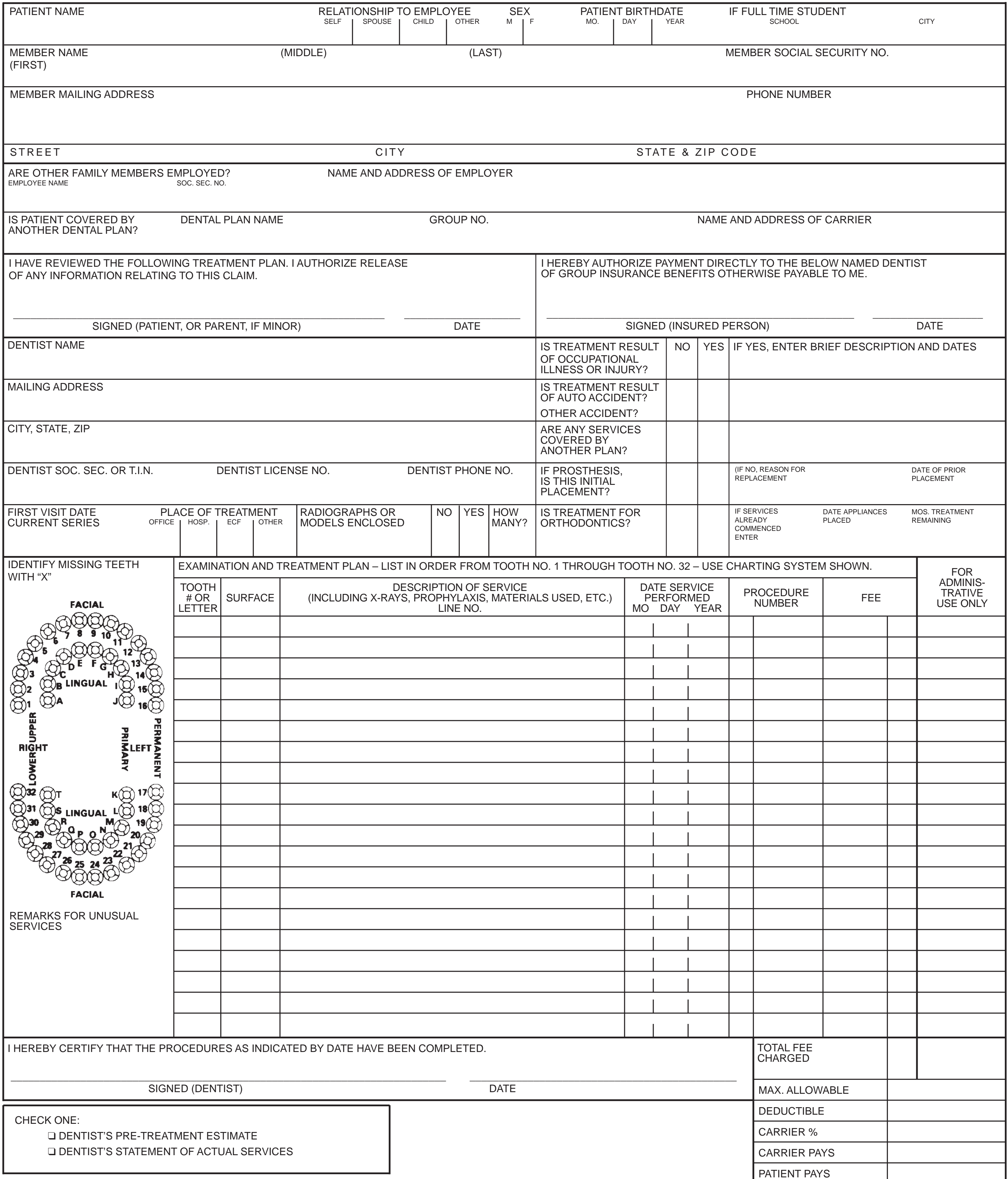
FOR ADDITIONAL FORMS
PHONE:
(301) 731-1064
Have your Social Security Number ready.

DENTAL CLAIM FORM
ELECTRICAL WELFARE TRUST FUND
4601 Presidents Drive, Suite 300, Lanham, Maryland 20706

INQUIRIES
PHONE:
(301) 731-1050
Have all papers available when you call.

IMPORTANT: Claims MUST Be Filed Within One Year

This portion to be completed by the employee



PATIENT NAME	RELATIONSHIP TO EMPLOYEE: SELF / SPOUSE / CHILD / OTHER	SEX: M / F	PATIENT BIRTHDATE: MO. / DAY / YEAR	IF FULL TIME STUDENT: SCHOOL / CITY

MEMBER NAME (FIRST)	(MIDDLE)	(LAST)	MEMBER SOCIAL SECURITY NO.

MEMBER MAILING ADDRESS		PHONE NUMBER
STREET	CITY	STATE & ZIP CODE

ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME / SOC. SEC. NO.	NAME AND ADDRESS OF EMPLOYER		
IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME	GROUP NO.	NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT, OR PARENT, IF MINOR) ______ DATE ______

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (INSURED PERSON) ______ DATE ______

DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?			
CITY, STATE, ZIP	ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SOC. SEC. OR T.I.N. / DENTIST LICENSE NO. / DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT / DATE OF PRIOR PLACEMENT
FIRST VISIT DATE CURRENT SERIES / PLACE OF TREATMENT: OFFICE, HOSP., ECF, OTHER / RADIOGRAPHS OR MODELS ENCLOSED: NO, YES, HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"

REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 – USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINIS-TRATIVE USE ONLY

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST) ______ DATE ______

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

CHECK ONE:
- ❑ DENTIST'S PRE-TREATMENT ESTIMATE
- ❑ DENTIST'S STATEMENT OF ACTUAL SERVICES