CHECK ONE:

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

DENTAL CLAIM FORM
ELECTRICAL WELFARE TRUST FUND
10003 Derekwood Lane, Suite 130, Lanham, Maryland 20706

IMPORTANT: Claims MUST Be Filed Within One Year

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

PATIENT NAME	RELATIONSHIP TO EMPLOYEE: SELF / SPOUSE / CHILD / OTHER	GENDER: M / F	PATIENT BIRTHDATE: MO. / DAY / YEAR
MEMBER NAME (FIRST)	(MIDDLE)	(LAST)	MEMBER ID NO.

MEMBER MAILING ADDRESS		PHONE NUMBER
STREET	CITY	STATE & ZIP CODE

IS PATIENT EMPLOYED? EMPLOYEE NAME / SOC. SEC. NO.	NAME AND ADDRESS OF EMPLOYER

OTHER DENTAL OR MEDICAL COVERAGE? Y N IF YES, LIST SSN: ______________________	OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME, ADDRESS, CITY, STATE, ZIP CODE
NAME OF POLICYHOLDER/SUBSCRIBER	POLICYHOLDER/SUBSCRIBER (SSN OR ID#)
PATIENT'S RELATIONSHIP TO PERSON NAMED DIRECTLY ABOVE ____SELF ____SPOUSE ____DEPENDENT CHILD ____OTHER	POLICYHOLDER DATE OF BIRTH (MM/DD/CCYY)
GENDER M I F	PLAN/GROUP NUMBER

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?			IF YES, DATE OF 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 **DO NOT SEND XRAYS**	NO	YES	HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

MISSING TEETH INFORMATION

(Place an 'X' on each missing tooth)

	Permanent																Primary									
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

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

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

SIGNED (DENTIST) ______________ DATE ______________

TOTAL FEE CHARGED

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

SIGNED (PATIENT, OR PARENT/GUARDIAN, 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 ______________

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