PRESSMEN WELFARE FUND

911 Ridgebrook Road
Sparks, Maryland 21152-9451
PHONE (888) 834-6966

DENTAL CARE CLAIM FORM

Type or Print **This portion to be completed by the employee**

1. Social Security Number

2. Employee's Name (Last, First and Middle)

3. Employee's Address (Street, City, State and Zip Code)

4. Patient's Name (Last, First and Middle)

5. Patient's Birthdate Mo Day Year

6. Patient's Relationship to Subscriber (Check Appropriate Box)
   Male ☐ Self (1) ☐ Spouse (3) ☐ Son (5)
   Female ☐ Self (2) ☐ Spouse (4) ☐ Daughter (6)

7. Employer

8. Is the patient covered under another Dental Benefits Plan? ☐ Yes ☐ No If yes: carrier name
policy holder _____ policy number _____ effective date _____ Individual ☐ Family ☐

9. Is treatment a result of injury? ☐ Yes ☐ No If yes date of injury _____ If yes did injury occur on the job? ☐ Yes ☐ No Worker's Compensation

10. I certify that the above information is correct and apply for benefits under my dental coverage with the plan, I authorize any dentist or physican in possession of information concerning the patient to furnish such information to the Plan upon request.
Signature of Employee _____ Date _____

11. Assignment of Benefits ☐ Yes ☐ No
If answer is yes sign again
Signature of Employee _____

Part II - Attending Dentist's Statement - Please Print

Name of Dentist (First, Last)

Dentist's Telephone Number

Dst's Office Location (No., Street, City, State, ZIP Code)

Dentist's Tax I.D.

New location? ☐ Yes ☐ No
More than 1 office? ☐ Yes ☐ No

Remarks

Name of Patient (Last, First, M.I.)

Is dentist related to patient by blood or marriage?
☐ Yes ☐ No Relationship _____

Orthodontic Treatment ➤ Date Appliance Inserted

Expected Treatment Duration: _____ Months

Class of Malocclusion ☐ I ☐ II ☐ III

Is treatment the result of an accident? ☐ Yes ☐ No
If Yes: ☐ Occupational ☐ Auto ☐ Other

For crown, bridge or other prosthesis is this initial placement? ☐ Yes ☐ No

If not, date of prior placement
Mo. _____ Year _____

Prior partial? ☐ Yes ☐ No

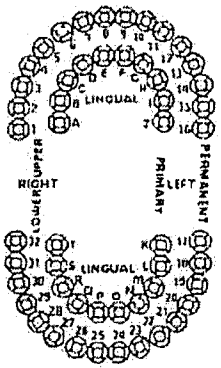
If No, Date of Extractions

Teeth Involved in Prior Prosthesis

Final Prep Date _____ Impression Date _____ Seat Date _____

IDENTIFY MISSING TEETH WITH AN "X" FOR ALL SUBMISSIONS

FACIAL



FACIAL

Examination and Treatment Plan- List in order from tooth No. 1-32 (Use Chart System Shown)

Tooth Number or Letter	Surface	Description of Service (including X-rays, prophylaxis, materials, etc.) Line No.	Date Service Performed MM DD YY	Procedure Number	Fee	For Administrative Use Only

Radiographs or Models Enclosed ☐ Yes ☐ No

Dentist's Signature

Date

☐ Check if X-Rays are to be returned to Dentist

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

PREDETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT - Recommended for charges of $200.00 or more. Predetermination of your claim advises you in advance of the amount of benefits payable if described procedures are performed during a period of patient's eligibility. Benefits payable are subject to COB and other policy provisions.