# PRESSMEN WELFARE FUND

7130 Columbia Gateway Drive, Suite A
Columbia, Maryland 21046
PHONE (410) 872-9500

## 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

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

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

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

**Orthodontic Treatment** ➤ Date Appliance Inserted

Expected Treatment Duration: _____ Months

Class of Malocclusion ☐ I ☐ II ☐ III

Dentist's Tax I.D.

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

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 _____

Remarks

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

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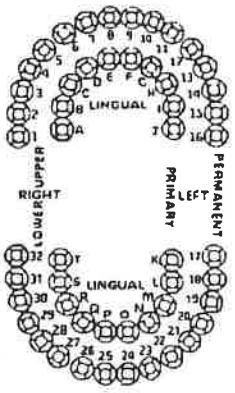


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## Examination and Treatment Plan- List in order from tooth No. 1-32 (Use Chart System Shown)

| 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 |
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Radiographs or Model 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.