Dental Claim Form

IBEW LOCAL NO 150 WELFARE FUND

6525 Centurion Drive
Lansing, MI 48917
(877) 478-4542

Check one:
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

1. Patient Name: last / first / m.i.	2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other:	3. Sex ☐ m ☐ f	4. Patient birthdate MM DD YYYY	5. If full time student school: city:

6. Employee/subscriber name and mailing address	7. Employee/subscriber Soc. Sec. or ID number	8. Employee/Subscriber birthdate MM DD YYY	9. Employer (company) name and address	10. Group Number

11. Is patient covered by another dental plan? ☐ No ☐ Yes If yes, complete 12-a.	12-a. Name and Address of carrier(s)	12-b. Group No(s)	13. Name and address of employer(s)

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ _____ _____
Signed (Patient, or parent if minor) Date

I hereby authorize payment of the dental benefits to me directly to the below named dental entity.

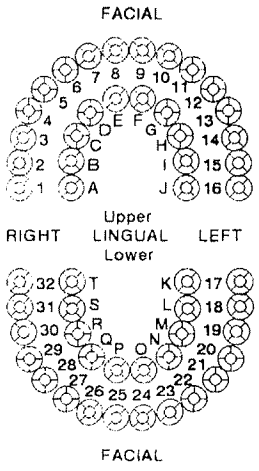
▶ _____ _____
Signed (Patient, or parent if minor) Date

16. Name of Billing Dentist or Dental Entity	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and date(s).
17. Address where payment should be mailed	25. Is treatment result of car or auto accident?			
City, State, Zip	26. Other accident?			

18. Dentist Soc. Sec. or TIN	19. Dentist License	20. Dentist Phone No.	27. If prosthesis, is this initial placement?		If no, reason for replacement?	Date of Prior Placement?

21. First visit date current series	22. Place of Treatment ☐ Office ☐ ECF ☐ Hosp. ☐ Other	23. Radiographs or models enclosed? ☐ Yes ☐ No	How Many?	28. Is treatment for orthodontics?			

Identify missing teeth with "X"



30. 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	Date Service performed	Procedure Number	Fee	For Admin use only

31. Remarks for unusual services	Total Fee Charged

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.

▶ _____ _____
Signed (Treating Dentist) Date