DENTAL CLAIM FORM — SIDE B

Patient's name and address	Birth Date
Covered participant's name if patient is a dependent (indicate address if different from patient)	Participant's Social Security Number

DENTIST INFORMATION (To be completed by Dentist) Complete as reported on W-9 form for 1099

DENTIST NAME AND DEGREE	PHONE #	FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT: OFFICE / HOSP / ECS / OTHER	DO NOT SEND X-RAYS UNLESS REQUESTED
MAILING ADDRESS		IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	YES / NO	(IF NO, REASON FOR PLACEMENT) DATE OF PRIOR PLACEMENT
CITY / STATE / ZIP		IS TREATMENT FOR ORTHODONTICS?	YES / NO	If crowns were made, were they for cosmetic purposes? YES / NO
MUST BE FURNISHED UNDER AUTHORITY OF LAW				
Taxpayer ID No		Treatment Result of Accident?		
Indivdual Practitioner's S. S. No.		Result of Occupational Injury?		

CHECK ONE: ☐ DENTIST'S PRETREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

Identify teeth number's being replaced by partial

FACIAL
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
LINGUAL
RIGHT UPPER LOWER — LEFT PRIMARY PERMANENT
17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
K L M N O P Q R S T
LINGUAL
FACIAL

Please advise the placement date of partials, crowns, and/or dentures

Examination and treatment plan — List in order from tooth No. 1 through tooth No. 32 — Use charting shown

Date Service Performed Mo.	Day	Yr.	DESCRIPTION OF SERVICES (Including X-rays, prophylaxis, materials used, etc.) DO NOT SEND X-RAYS UNLESS REQUESTED	Procedure Number	Fee	Tooth # or Letter	Surfaces (i.e., M.O. D.B.L.L.A.I.)	DO NOT USE THIS COLUMN
				TOTAL FEE CHARGED				

Please complete if PREDETERMINATION is being requested:

NOTE TO DENTIST: Pre-Authorization is not a Requirement.

The treatment listed above **will be** performed by me.

Dentist's Signature ____________ Date ____________ Degree ____________

Please complete **AFTER** procedures are performed: I hereby certify that the procedures as indicated by date have been completed by me.

Dentist's Signature ____________ Date ____________ Degree ____________

I hereby authorize payment directly to the above named dentist of the benefits otherwise payable to me, but not to exceed the charges shown above. I understand that I am financially responsible for any charges not covered by the Boilermakers National Health and Welfare Fund.

PARTICIPANT'S SIGNATURE ____________ DATE ____________

Please Note: Pretreatment Review is not a guarantee of benefits payable.
This estimate advises you in advance of the amount of benefits payable if the described procedures are performed during a period of the patient's eligibility.

WHEN REQUESTING PREDETERMINATION — Send claim to address on reverse side of form. Keep a copy of the form and when treatment plan is completed submit to the Fund Office with the dates of service indicated and the dentist's signature as provided above.

SIDE A

DENTAL CLAIM FORM

IMPORTANT READ CAREFULLY

*** It is a crime to fill out this form with facts you know are false or to leave out facts you know are important.**

1. Participant must complete Side A and have provider complete Side B.
2. Include all bills itemized to show expense incurred.
3. Be sure to show participants Social Security Number in order that we may locate your records.
4. Return completed form to this address as soon as possible:

BOILERMAKERS NATIONAL HEALTH AND WELFARE FUND
754 Minnesota Ave., Suite 522
Kansas City, Kansas 66101-2766

PATIENT & PARTICIPANT INFORMATION (To be completed by Participant) (PLEASE TYPE OR PRINT)

Participant's Name ______________________ Date of Birth ________ (Month) (Day) (Year)

Marital Status: ☐ Single ☐ Married ☐ Divorced

Home Address ______________________ Telephone No. ______________

______________________ (City) (State) (Zip Code) Participant's Social Security No. ______________

Last Employer ______________ Months Worked ______________ Local ________

Is this your first claim with the Fund? __________ Are you retired? __________

Name of Patient ______________________ Patient's Date of Birth ________ (Month) (Day) (Year)

PATIENT'S SEX

☐ Male ☐ Female

Patient's Address (If Different From Participant)

☐ Single ☐ Married

PATIENT'S RELATIONSHIP TO PARTICIPANT

☐ Self ☐ Spouse ☐ Child ☐ Other

FULL TIME STUDENT - AT LEAST 12 CREDIT HOURS (Complete only if claim for child age 19 to 23)

☐ Yes ☐ No IF YES, WHERE AND LAST DATE ATTENDED:

Date first dental expense incurred ______________ Was dental expense due to injury? ☐ Yes ☐ No

WAS CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT?
☐ Yes ☐ No

B. AN AUTO ACCIDENT?
☐ Yes ☐ No

C. OTHER ACCIDENT?
☐ Yes ☐ No

IF AN ACCIDENT:

Date ______________, 19 ______ AND TIME ________ ☐ A.M. ☐ P.M.

SPECIFIC DESCRIPTION OF HOW AND WHERE ACCIDENT OCCURRED:

Has claim been filed or will claim be filed under any Worker's Compensation Act or similar law? ______________

Give the dentist's name and address ______________

Do you or patient have other Group Health coverage? ☐ **Yes** ☐ **No.** **If answer is Yes, complete below:**

Do you or patient have other Group Dental coverage? ☐ **Yes** ☐ **No.**

Plan Name ______ Name of Policy Holder ______ Social Security Number of Policy Holder ______

Plan Address ______ Policy Number ______

Does Plan Follow Birthday Rule? .... ☐ Yes ☐ No

Do you or patient have Medicare? ☐ **Yes** ☐ **No. If answer is Yes, complete the following and submit a copy of the Medicare Card(s).**

Plan Name ______ Name of Policy Holder ______ Social Security Number of Policy Holder ______

Plan Address ______ Policy Number ______

IS SPOUSE EMPLOYED? ☐ Yes ☐ No

EMPLOYER'S NAME ______________________

EMPLOYER'S ADDRESS ______________________

CERTIFICATION AND AUTHORIZATION: I/WE certify that the above statements and answers, including any accompanying bills are true and complete to the best of our knowledge and belief. I/We know it is a crime to fill out this form with facts I/We know are false or to leave out facts I/We know are important. I/We authorize the Boilermakers National Health and Welfare Fund to release or request any medical or other information necessary to process this claim. A photocopy of this authorization shall be as valid as the orginal.

Participant's Signature ______ Spouse's Signature ______ Date ______

MUST HAVE BOTH SIGNATURES AND DATE