DENTAL CLAIM FORM

PLUMBERS & PIPEFITTERS MEDICAL FUND

7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046 1-800-741-9249

THIS SIDE OF FORM TO BE COMPLETED BY MEMBER

1. Employee's Name _____ Date of Birth _____
   Last First Initial
2. Social Security Number ☐☐☐-☐☐-☐☐☐☐ ☐ Male ☐ Female ☐ Single ☐ Married
3. Spouse's Name _____ Date of Birth _____
   Last First Initial
4. Home Address _____
   ☐ Check if new address Street Address City State Zip
5. Employee Work Status ☐ ACTIVE ☐ RETIRED _____ ☐ TERMINATED _____
   Date Retired Date Terminated
   ☐ LAYOFF _____ ☐ DISABLED _____ _____
   Date Last Worked Date Last Worked Date Returned to Work

PATIENT INFORMATION

6. Patient's Name _____ Patient's Soc. Sec. No. ☐☐☐-☐☐-☐☐☐☐
7. Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other (Specify) _____
8. Birthdate _____ ☐ Male ☐ Female ☐ Single ☐ Married
9. If Patient is a dependent child 19 years or older, is he/she a full-time student? ☐ Yes ☐ No
   If yes, _____
   Name of School Location Expected Graduation Date
10. Patient's Address if not same as employee's _____
    Street Address City State Zip
11. Was condition related to Patient's Employment? ☐ Yes ☐ No
12. If sickness, date symptoms first noticed _____ Date doctor consulted _____
    If accident, date and time of accident _____ ☐ AM ☐ PM
    Was another person at fault? ☐ Yes ☐ No Describe how and where accident occurred _____
    _____

FAMILY INFORMATION

13. Are any other members of your family employed? ☐ Yes ☐ No If Yes, complete the following:

Name	Relationship	Date of Birth	Social Security Number	Employer Name and Address

14. Does employee or any family member have other health insurance? ☐ Yes ☐ No
    Name of family member(s) _____ Birthdate(s) _____
    _____ _____

Type of Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drugs

Type of Insurance ☐ Other Employer Sponsored Plan ☐ HMO ☐ Medicare ☐ No Fault Insurance
☐ School Sponsored Plan ☐ CHAMPUS ☐ Other _____

Name/Address of Other Insurance Company or Administrator	Coverage Effective Date	Plan Number

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any Dentist, Physician, Health Professional, Supplier, Hospital, Pharmacy, Insurance Company, Employer, or Organization to release any information (including that related to mental illness) about myself and my dependents requested by Plumbers and Pipefitters Medical Fund and its consulting professionals, for the exclusive purpose of administering the provisions of Health Plan benefits to which I am entitled. This authorization shall extend to all services and claims and is valid for the term of coverage of the Health Plan. A copy of this document shall be as valid as the original.

☛ Patient's or Authorized Person's Signature _____ Date _____

WARNING: Anyone who intentionally includes false or misleading information in an attempt to defraud or deceive is guilty of a crime.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE

I authorize payment to be made directly to the provider of the services covered by this claim form.

☛ Employee's Signature _____ Date _____

ATTENDING DENTIST'S STATEMENT

TREATMENT PLAN AND CLAIM REPORT

TO BE COMPLETED BY DENTIST

CHECK ONE ❒ DENTIST'S PRE-TREATMENT ESTIMATE OF CHARGES

❒ DENTIST'S STATEMENT OF ACTUAL CHARGES

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE SELF / SPOUSE / CHILD / OTHER	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YEAR	5. IF FULLTIME STUDENT SCHOOL / CITY

6. EMPLOYEE NAME FIRST / MIDDLE / LAST	7. EMPLOYEE SOCIAL SECURITY NUMBER	9. NAME OF GROUP DENTAL PROGRAM

8. EMPLOYEE MAILING ADDRESS	10. EMPLOYER (COMPANY) NAME
CITY, STATE, ZIP	MAILING ADDRESS / CITY, STATE, ZIP

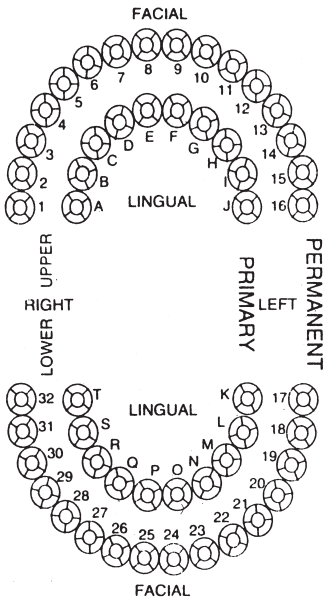
11. GROUP NUMBER	12. LOCATION (LOCAL)	13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME / SOC. SEC. NO.	14. NAME AND ADDRESS OF EMPLOYER, ITEM 13.

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ❒ YES ❒ NO	DENTAL PLAN NAME	GROUP NO.	NAME AND ADDRESS OF CARRIER

16. DENTIST NAME	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO / YES	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT. NO / YES
17. MAILING ADDRESS	25. IS TREATMENT RESULT OF AUTO ACCIDENT?	29. DATE OF PRIOR PLACEMENT
CITY, STATE, ZIP / 18. DENTIST PHONE NO.	26. OTHER ACCIDENT?	30. IS TREATMENT RELATED TO TMJ?
19. DENTIST TAX I.D. OR SOC. SEC. NO. / 20. DENTIST LICENSE NO.	27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	31. IS TREATMENT RELATED TO IMPLANTOLOGY?

21. FIRST YEAR DATE CURRENT SERIES	22. PLACE OF TREATMENT OFFICE / HOSP / ECF / OTHER	23. RADIOGRAPHS OR MODELS ENCLOSED? ❒ YES ❒ NO / HOW MANY?	32. IS TREATMENT FOR ORTHODONTICS? ❒ YES ❒ NO	IF SERVICES ALREADY COMMENCED ENTER... DATE APPLIANCES PLACED / TREATMENT REMAINING (MONTHS)

IDENTIFY MISSING TEETH WITH "X"



EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH 32. USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO	DAY	YR	ADA PROCEDURE NUMBER	FEE	FOR PLAN ADMINISTRATOR USE ONLY

33. REMARKS FOR UNUSUAL SERVICES

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED AND PAYMENT IS THEREFORE DUE.

SIGNED (DENTIST) (DATE)

TOTAL FEE ACTUALLY CHARGED		
PATIENT PAYS		
BALANCE		

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