

**SHEET METAL WORKERS LOCAL UNION NO. 32  
HEALTH AND WELFARE FUND  
Zenith Administrators  
P.O. Box 721380  
Houston, TX 77272-1380  
713-219-1200 or Toll Free 866-521-7632**

**Dental Expense Claim**

**To Be Completed by Employee**

1. Patient First Name Middle Last		2. Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Patient Date of Birth Mo. / Day / Year	6. For Office Use
7. If Full-Time Student (Age 19 or Over) School City State			8. EMPLOYEE Social Security / ID Number		9. If Disabled (Age 19 or Over) <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Name of Group Dental Program
11. Employee First Name Middle Last			12. Employee Date of Birth		13. Office Phone (Area Code)		
14. Employee Residence Mailing Address				15. City, State, Zip			
16. Are other Family Members Employed? Name Social Security / ID Number			17. Date of Birth		18. Name and Address of Employer for Item 16		
19. Is Patient Covered by Another Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete the following:) Dental Plan Name Group No. Name and Address of Carrier							
20. I Authorize Release of any Information Relating to this Claim.  (Signature of Patient or Signature of Authorized Representative if Minor) _____ Date _____  If Authorized Representative, Relationship to Minor _____		21. I Certify that the Above Information is Correct.  Employee Signature _____ Date _____		22. I Authorize Payment Directly to the Below-Named Dentist.  Employee Signature _____ Date _____			

**To Be Completed by Dentist**

23. Dentist Name		24. Mailing Address City State Zip	
25. Dentist Phone Number	26. Dentist License Number	27. Dentist SSN or T.I.N.	28. Provider Specialty Code
29. NPI (Treating Dentist)	30. NPI (Billing Entity, if different)		31. First Visit Date Current Series
32. Place of Treatment <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other		33. Radiographs or Models Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No How Many?	
34. Is Treatment Result of Occupational Illness or Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates)		35. Is Treatment Result of Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates)	
36. Other Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates)		37. Are any Services Covered by Another Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates)	
38. If Prosthesis, is this Initial Placement? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, Reason for Replacement)			39. Date of Prior Replacement
40. Is Treatment for Orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Services Already Commenced, Enter Date Appliance Placed		Months of Treatment Remaining

**Dentist's -  Pretreatment Estimate  Statement of Actual Services (Be sure to sign below)\***

	41. Examination and Treatment Plan - List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)						
	Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo./ Day /Year	ADA Procedure Number	Fee	For Carrier Use Only

42. I Herby Certify That The Services Listed Above  Will Be  Have Been Performed.

\*Signature of Dentist \_\_\_\_\_ Date Signed \_\_\_\_\_ Total Fee Actually Charged \_\_\_\_\_

43. Address where treatment was performed

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_