

Sheet Metal Workers Local Union No. 32 Health & Welfare Fund

c/o National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100 • Pembroke Pines, FL 33028
(954) 266-6322 • (800) 842-5899 • Fax (954) 266-2079



Dental Expense Claim Form

Important Information:

1. This dental claim form must be submitted at least once annually to ensure the Fund Office has up to date information. One form is required for each patient.
2. Your dentist should submit the standard American Dental Association claim form in order to file a claim on your behalf. Your dentist may also use the reverse side of this form.
3. Make sure that all sections of this form are completed.
4. Please note that the **member's** (employee's) signature is required on this form.
5. Mail completed form to:

SM32 H & W Fund - Att: Claims
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, FL 33028

6. Please verify your coverage with the Fund Office at (954) 266-6322 or (800) 842-5899.

| Member/Employee Information: | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Member Name: _____ <i>First Middle Initial Last</i> | 2. Member SSN: _____ - _____ - _____ |
| 3. Mailing Address: _____ | 4. Home Phone: () - Alternate Phone: () - |
| Patient Information: | |
| 5. Patient Name: _____ <i>First Middle Initial Last</i> | 6. Patient's Date of Birth: _____ / _____ / _____ |
| 7. Patient's Relationship to Member/Employee: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child | 8. Is this Patient Covered by Another Insurance Policy? <input type="radio"/> No <input type="radio"/> Yes (If Yes, complete questions 9 and 10) |
| 9. Name and Telephone Number of Patient's Other Insurance Carrier: | 10. Other Insurance Carrier - Insured's Name and ID #: |
| Member/Employee Certification: | |
| I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim to plan benefit provisions. | |
| Member/Employee Signature: _____ | Date: _____ |
| Patient Signature: _____ | Date: _____ |

**Sheet Metal Workers Local Union No. 32 Health & Welfare Fund
Dental Expense Claim**

| Dentist Information: | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------|----------------------|---------------------|
| 11. Attending Dentist: | | | 12. Federal Tax ID # or Dentist's SSN: | | |
| 13. Mailing Address: | | | 14. Phone Number: () - | | |
| 15. Provider Specialty Code: | 16. Is this claim the result of an accident? <input type="radio"/> No <input type="radio"/> Yes | | 17. Is this claim the result of an occupational injury? <input type="radio"/> No <input type="radio"/> Yes | | |
| 18. Place of Service Code: | 19. If prosthesis, is this initial placement? <input type="radio"/> No <input type="radio"/> Yes (If no, complete question 20) | | 20. Please indicate reason for replacement of prosthesis: | | |
| 21. Please indicate if claim is a: <input type="radio"/> Pre-Treatment Estimate <input type="radio"/> Statement of Actual Services Rendered | | | | | |
| 22. Examination and Treatment Plan - List in Order From Tooth # 1 through Tooth # 32 (Use Charting System Shown) | | | | | |
| Tooth # or Letter | Surface | Description of Services | Date Performed | ADA Procedure Number | Charge |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| 23. Missing Teeth Info. | | Permanent | | Primary | |
| Place an 'X' on each missing tooth | | 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 |
| | | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17 | T S R Q P | O N M L K |
| | | | | | Total Charge |
| 24. I hereby certify that the services listed are in progress (for procedures that require multiple visits) or have been completed. | | | | | |
| Signature of Dentist: _____ | | | Date: _____ | | |
| 25. I hereby authorize payment directly to the above named dentist. | | | | | |
| Signature of Employee: _____ | | | Date: _____ | | |