DENTAL CLAIM FORM

SHEET METAL WORKERS
LOCAL NO. 110 WELFARE FUND

RETURN THIS FORM TO:
American Benefits Corporation
3150 Rt 60
Ona, WV 25545
(304) 525-0331 - Claims

PLEASE INDICATE
☐ Pre-Treatment Estimate (Services in Excess of $200)*
☐ Actual Charges

TO BE COMPLETED BY THE EMPLOYEE
Employee's Name ☐ Married ☐ Single Social Security Number

Employee's Address Number and Street City State Zip Code

Claim is For Dependent's Name Dependent's Date of Birth

(Circle One) Self Spouse Child

Is the person for whom this claim is being made covered by any other group plan? ☐ Yes ☐ No

Name of Group Policy Number

Name of Insurance Company Address

I authorize release to the Plan of any information required to process my claim. A photocopy of this authorization may be honored.

Employee's Signature

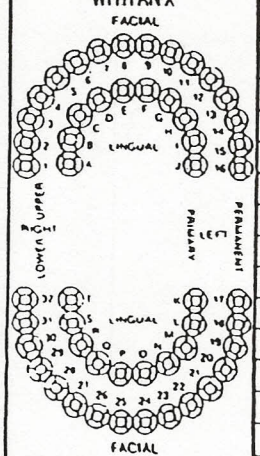
I hereby authorize payment directly to the named Dentist for the services described.

Employee's Signature

TO BE COMPLETED BY THE DENTIST

DENTIST NAME			IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES		
ADDRESS			IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?					
CITY, STATE, ZIP			ARE ANY SERVICES COVERED BY ANOTHER PLAN?					
DENTIST SOC. SEC. NO. OR TAX I.D. NO.	DENTIST LICENSE NO.	DENTIST PHONE NO.	IF PROTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT)		DATE OF PRIOR PLACEMENT
FIRST VISIT DATE	PLACE OF TREATMENT: OFFICE / HOSP. / ECF / OTHER	RADIOGRAPHS OR MODELS ENCLOSED	NO	YES	HOW MANY?	IS TREATMENT FOR ORTHODONTICS?		DATE APPLIANCES PLACED (IF SERVICES ALREADY COMMENCED ENTER) / MOS. TREATMENT REMAINING

INDICATE MISSING TEETH WITH AN X



REMARKS

EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH 12
USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE
				TOTAL	

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE DATES INDICATED.

DENTIST'S SIGNATURE DATE: