DENTAL CLAIM FORM

4TH DISTRICT IBEW HEALTH FUND

RETURN THIS FORM TO:
American Benefit Corporation
3150 U. S. Route 60
Ona, WV 25545
304-525-0331
888-466-9094

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 4th District IBEW Health Fund of any information required to process my claim. A photocopy of this authorization may be honored.

Employee's Signature

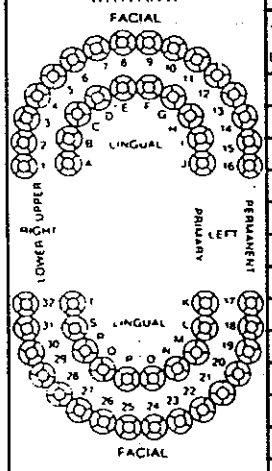
I hereby authorize payment directly to the named Dentist for the services described.

Employee's Signature

TO BE COMPLETED BY THE DENTIST

DENTIST NAME			IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	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 LO. 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



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	

REMARKS

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

DENTIST'S SIGNATURE DATE: