THE NATIONAL ASBESTOS WORKERS MEDICAL FUND

7130 Columbia Gateway Drive, Suite A, Columbia, Maryland 21046
(800) 386-3632 (410) 872-9500

DENTAL CARE CLAIM FORM

Type or Print — **This portion to be completed by the employee**

1. **Social Security Number**

2. **Employee's Name** (Last, First and Middle)

3. **Employee's Address** (Street, City, State and Zip Code)

4. **Patient's Name** (Last, First and Middle)

5. **Patient's Birthdate** Mo. Day Year

6. **Patient's Relationship to Subscriber** (Check Appropriate Box)
   Male ☐ Self (1) ☐ Spouse (3) ☐ Son (5)
   Female ☐ Self (2) ☐ Spouse (4) ☐ Daughter (6)

7. **Employer**

8. **Is the patient covered under another Dental Benefits Plan?** ☐ Yes ☐ No **If yes: carrier name**
   policy holder _____ policy number _____ effective date _____ Individual ☐ Family ☐

9. **Is treatment a result of injury?** ☐ Yes ☐ No If yes, date of injury _____ If yes, did injury occur on the job? ☐ Yes ☐ No **Worker's Compensation**

10. **I certify that the above information is correct and apply for benefits under my dental coverage with the plan. I authorize any dentist or physician in possession of information concerning the patient to furnish such information to the Plan upon request.**
    Signature of Employee _____ Date _____

11. **Assignment of Benefits** ☐ Yes ☐ No
    If answer is yes sign again
    Signature of Employee _____

Type or Print — **This portion to be completed by the dentist**

12. **If prosthesis, is this initial placement?** ☐ Yes ☐ No Date of original prosthesis Reason for replacement

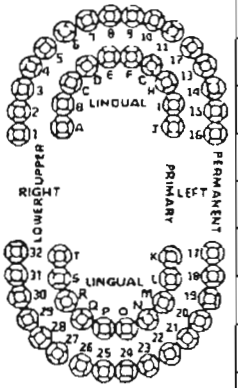
13. **Is orthodontic treatment included in the services listed below?** ☐ Yes ☐ No
    Is this initial treatment? ☐ Yes ☐ No

14. **X-ray or models enclosed?** ☐ Yes ☐ No

15. **For services involving missing teeth, indicate tooth number and date tooth was lost or extracted:**
    Tooth _____ Date _____ Tooth _____ Date _____ Tooth _____ Date _____ Tooth _____ Date _____
    Tooth _____ Date _____ Tooth _____ Date _____ Tooth _____ Date _____ Tooth _____ Date _____

IDENTIFY MISSING TEETH WITH AN "X" FOR ALL SUBMISSIONS

FACIAL



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16. Description of Services (For description of unusual services, see reverse side)

plan use only

Tooth No. or Letter	Surfaces	Detailed description of services including x-rays (show quantity, materials, etc.)	Date of Service M	D	Y	A D A Procedure Code	Total Chg Each Serv	No. of Times Perf	Teeth or Range						Elig.	Act.	Reproc Code	Alt. Proc Code
		Total																

☐ _____ **PREDETERMINATION OF BENEFITS** _____
The treatment listed is necessary in my professional judgement and I request **Predetermination of Benefits.**

☐ _____ **WORK COMPLETED—PAYMENT REQUESTED** _____
I certify that the above services have been performed by me or under my personal supervision and are necessary in my professional judgment. Charges shown are my usual charges.

Dentist's Signature

Dentist's Name

Address

City **State** **Zip Code**

Tax Paying ID No.