DENTAL FORM

OPERATING ENGINEERS No. 99 BENEFIT FUND

5901 HARFORD ROAD, SUITE C BALTIMORE, MD 21214

(410) 254-9595 1-800-367-7848

STATEMENT OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF SERVICE

Member S.S. #_____

1. Patient Name
2. Relationship to Employee: Self | Spouse | Child | Other
3. Sex: M | F
4. Patient Birthdate: Mo. | Day | Year
5. If Full Time Student: School | City

6. Employee/Subscriber Name: First | Middle | Last
7. Employee/Subscriber Social Security No.
9. Name of Group Dental Program

8. Employee/Subscriber Mailing Address
10. Employer (Company) Name and Address

City, State, Zip

11. Group No.
12. Location (Local)
13. Are other family members employed? Employee Name | S.S. No.
14. Name and Address of Employer in Item 13

15. Is patient covered by another Dental Plan? Dental Plan Name | Union Local | Group No. | Name and Address of Carrier

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signed (Patient or Parent, if Minor) _____ Date _____

I hereby authorize payment directly to the below-named dentist of the Group Insurance Benefits otherwise payable to me.

Signed (Insured Person) _____ Date _____

16. Dentist Name
17. Mailing Address

City, State, Zip

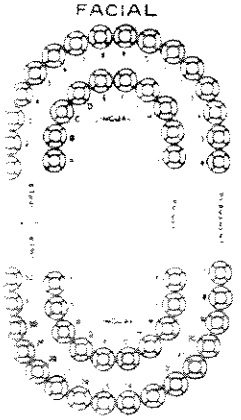
18. Dentist (Soc. Sec. or T.I.N.)
19. Dentist Lic. No.
20. Dentist Phone No.

21. First Visit Date Current Series
22. Place of Treatment: Office | HOSP | ECF | Other
23. Radiographs or Models enclosed? No | Yes | How Many?

24. Is treatment result of occ. illness or injury? No | Yes | If Yes, enter brief description and dates
25. Is treatment result of Auto Ac.
26. Other accident?
27. Are any serv. covered by another plan?
28. If prosthesis, is this initial placement? (If no, reason for replacement)
29. Date of prior placement
30. Is treatment for Orthodontics? If Services Already Commenced, Enter: Date Appliances Placed | Mo. Trmt. Remaining

IDENTIFY MISSING TEETH WITH "X"

FACIAL



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31. Examination and Treatment Plan—List in order from Tooth No. 1 thru Tooth No. 32—Use charting system shown.

Tooth No. or Let.	Surface	DESCRIPTION OF SERVICE (Including X-Rays, Prophylaxis, Materials Used, Etc) LINE NO.	Date Service Performed Mo. Day Yr.	Procedure Number	FEE	FOR ADMINISTRATIVE USE ONLY

32. Remarks for unusual services.

I hereby certify that the procedures as indicated by date have been completed.

Signed (Dentist) _____ Date _____

TOTAL FEE CHARGED

Max. Allowable