DENTAL CLAIM FORM

SEND TO: NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN
P.O. BOX 475
NEWTOWN SQUARE, PA 19073-0475
1-800-CLAIM11 OR 1-800-252-4611

CHECK ONE

[ ] DENTIST'S PRE-TREATMENT ESTIMATE

[ ] DENTIST'S STATEMENT OF ACTUAL SERVICES

PART 1 MEMBER PLEASE READ INSTRUCTIONS ON REVERSE, THEN COMPLETE PART 1 BEFORE TAKING THIS FORM TO YOUR DENTIST'S OFFICE

1. PATIENT NAME
2. RELATIONSHIP TO MEMBER: SELF | SPOUSE | CHILD | OTHER
3. SEX: M | F
4. PATIENT BIRTHDATE: MO. | DAY | YEAR
5. IF FULL TIME STUDENT: SCHOOL | CITY

6. MEMBER NAME: FIRST | MIDDLE | LAST
7. MEMBER SOCIAL SECURITY NO.

MEMBER DATE OF BIRTH: MONTH | DAY | YEAR

8. MEMBER MAILING ADDRESS
9. NAME OF YOUR EMPLOYER IN THE ELEVATOR INDUSTRY

CITY, STATE, ZIP

10. LOCAL UNION NUMBER

MEMBER PHONE NO.: AREA CODE | NUMBER

11. FOR ADMINISTRATIVE USE ONLY
12.
13. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO
If yes, indicate: NAME | SOC. SEC. NO.
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO

IF YES, SPOUSE'S DATE OF BIRTH: MONTH | DAY | YEAR

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 DENTAL PLAN BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (MEMBER) ____________ DATE ____________

PART 2 DENTIST BEFORE COMPLETING PART 2, PLEASE READ INSTRUCTIONS ON REVERSE SIDE

16. DENTIST NAME

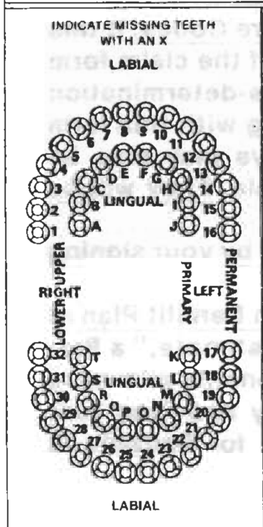
17. MAILING ADDRESS

CITY, STATE, ZIP

18. DENTIST SOC. SEC. OR T.I.N.*
19. DENTIST LICENSE 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?

	NO	YES	
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS OR CROWN(S), 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 | MOS. TREATMENT REMAINING



31. EXAMINATION AND TREATMENT PLAN—LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32—USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

32. REMARKS FOR UNUSUAL SERVICES

TOTAL FEE $

PART 3

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

SIGNED (DENTIST) ____________ DATE ____________

*Must be furnished under Authority of Law when Benefits Assigned

ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

HOW TO USE THIS FORM

MEMBER'S INSTRUCTIONS

- You should complete Part 1 of this form. Fill in all information for items 1 through 10 and 13 through 15. If any item is left blank, a request for such information may be generated from the claim paying office . . . creating an otherwise avoidable and unnecessary delay in the processing of your claim for benefits.
- Payment will be made directly to the dentist only if you sign your name in the right-hand box of the last line in Part 1. Otherwise, the payment will be sent to you.
- Ask the dentist, in advance, how much the total fee will be.

IF $250 OR MORE, YOU MAY ASK FOR A PRE-DETERMINATION OF BENEFITS AS FOLLOWS:

1. Prior to receiving treatment, have your dentist complete this form as a "Dentist's Pre-Treatment Estimate" and send to National Elevator Industry Health Benefit Plan.
2. National Elevator Industry Health Benefit Plan will send a Pre-Determination of Benefits to you and to your dentist so that you and your dentist may review the benefits allowable prior to services being performed.
3. The dentist will return the Pre-Determination of Benefits form to National Elevator Industry Health Benefit Plan when the work is completed. Payment is based on patient's eligibility and Plan provisions in effect at the time services were actually received and will be sent to you or the dentist, depending on your election in Part 1 of this form.

IF LESS THAN $250, OR EMERGENCY TREATMENT

1. The dentist performs the necessary services, checks "Dentist's Statement of Actual Services" at the top of the form, completes Parts 2 and 3, and sends the form to National Elevator Industry Health Benefit Plan. Instructions for the dentist are below.
2. Payment is based on patient's eligibility and Plan provisions in effect at the time services were actually received and will be sent to you or the dentist, depending on your election in Part 1 of this form.

DENTIST'S INSTRUCTIONS

1. At the top of the form check the applicable box for either "Dentist's Pre-Treatment Estimate" or "Dentist's Statement of Actual Services."
2. Complete Part 2 using Nomenclature and applicable American Dental Association Procedure Codes. If this course of treatment includes crowns or any type of prosthesis, please indicate in Item 28 of the claim form whether this is THE INITIAL OR REPLACEMENT CROWN/PROSTHESIS. In order to expedite pre-determination of benefits and final payment, it is suggested that pre-treatment X-rays be submitted along with this form when the course of treatment includes gold restorations, crowns, or bridgework. X-rays may also be requested for other services. Please staple the X-rays to the claim form whenever possible. They will be returned promptly.
3. If you have checked "Dentist's Statement of Actual Services," then Part 3 must be completed by your signing and dating of the form.
4. Send the form with any necessary pre-treatment X-rays to National Elevator Industry Health Benefit Plan at the address shown on the top of the form. If you have checked "Dentist's Pre-Treatment Estimate," a Pre-Determination of Benefits form will be returned to both you and your patient indicating the benefits allowable for the course of treatment submitted. All benefits are subject to the patient's eligibility and Plan year payments to date at the time services are actually provided and the subsequent claim for benefits is processed.

SUPPLEMENTARY INSTRUCTIONS FOR ORTHODONTIC TREATMENT

Please supply the following information on the Dental Claim Form:

A. Class of malocclusion.
B. Total charge for treatment.
C. Estimated length of active treatment.
D. Date initial appliance was or will be inserted.