DENTAL CLAIM

NORTHWEST IRONWORKERS HEALTH AND SECURITY TRUST FUND

EMPLOYEE STATEMENT

☐ **Check here if your address is new.**

PART 1 – EMPLOYEE INFORMATION

EMPLOYEE NAME – First Initial Last	☐ M ☐ F	EMPLOYEE SSN or WPAS ID.	EMPLOYEE BIRTHDATE Mo. Day Year
HOME ADDRESS STREET CITY STATE ZIP			PHONE
EMPLOYED BY		LOCAL NO.	EMAIL
PATIENT'S NAME – First Initial Last	☐ M ☐ F	PATIENT SOCIAL SECURITY NO.	PATIENT BIRTHDATE Mo. Day Year / RELATION TO EMPLOYEE Self Spouse Child

EMPLOYEE MARITAL STATUS	IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU	IF DEPENDENT CHILD IS AGE 26 OR OLDER,
☐ MARRIED ☐ LEGAL SEP. ☐ SINGLE ☐ WIDOWED ☐ DIVORCED	☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ FOSTER CHILD ☐ STEP CHILD ☐ GUARDIANSHIP ☐ OTHER (EXPLAIN) _____	DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP THAT BEGAN PRIOR TO REACHING AGE 26? ☐ YES ☐ NO

NAME OF SPOUSE (if not patient listed above)	SPOUSE BIRTHDATE Mo. Day Year	SPOUSE SOCIAL SECURITY NO.
IS SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME & ADDRESS SPOUSE'S EMPLOYER	

PART 2 – INSURANCE INFORMATION

ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN OR MEDICARE? ☐ YES ☐ NO

IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER NAME _____ ADDRESS_____

NAME OF SUBSCRIBER _____ SUBSCRIBER SOCIAL SECURITY NO. _____

OTHER GROUP PLAN COVERS: ☐ PATIENT ☐ SPOUSE ☐ CHILDREN OTHER GROUP PLAN POLICY OR I.D. NO. _____

OTHER GROUP PLAN INCLUDES: ☐ MEDICAL ☐ DENTAL ☐ VISION

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY AUTHORIZE MY DOCTOR TO FURNISH AND DISCLOSE ALL FACTS CONCERNING THE CLAIM FOR BENEFITS.

EMPLOYEE'S SIGNATURE X _____ **DATE** ____/____/____

PROCEDURE FOR FILING A CLAIM

INSTRUCTIONS TO THE EMPLOYEE:

1. Complete all applicable sections of Part 1-Employee Information and Part 2-Insurance Information. Failure to properly complete these sections may result in a delay in processing your claim.
2. Be sure to sign where indicated on Part 1. If you want the dental benefit payment sent directly to your dentist, sign on the bottom line of Part 3 (see reverse side of this form).
3. Complete a separate form for each patient.
4. Take this form to your dentist on your first visit. Upon completion of treatment complete and forward the form to the address below.

INSTRUCTIONS TO THE DENTIST:

1. **Predetermination of cost is required if proposed treatment is extensive.**
2. Complete Part 3-Dentist Information, answer all questions and indicate all treatment performed.
3. Indicate on the chart all missing teeth with an "X" and all abutments with an "O".
4. Describe procedures for treatment of this case, give the date of service and the fee charged for each procedure. The use of the standard ADA codes will expedite the processing of this claim.
5. For payment to be made directly to the dentist, the **employee must sign the bottom line on the reverse side of this form.**

Upon completion of treatment, return this form to:

NW Ironworkers Trust
PO Box 34464
Seattle, WA 98124-1498
OR
EMAIL: claimstatus@wpas-inc.com

PHONE: (206) 441-7574 OR (866) 986-1515
FAX: (206) 441-9110

NOTE: If you have other Group Insurance as your primary coverage, you need to submit the itemized bill AND a copy of the matching insurance payment Explanation of Benefits.

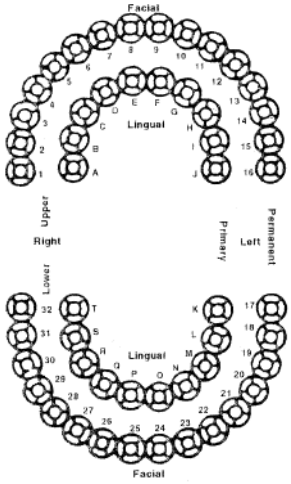
PART 3 – DENTIST INFORMATION

DENTIST NAME	TELEPHONE NUMBER		IS PATIENT COVERED BY ANOTHER PLAN? IF "YES", ENTER NAME OF OTHER PLAN	YES	NO
DENTIST MAILING ADDRESS					
DENTIST CITY	STATE	ZIP	IS ANY OF THE TREATMENT FOR ORTHODONTIC PURPOSES?		
YOUR TAX IDENTIFICATION NUMBER		NPI	TREATMENT RESULT OF ACCIDENT?		
OTHERWISE YOUR SOC. SEC. NO.			TREATMENT RESULT OF OCCUPATIONAL INJURY?		
(MUST BE FURNISHED UNDER AUTHORITY OF LAW)			ARE X-RAYS ENCLOSED? IF "YES", HOW MANY?		

IF PROSTHESIS, IS THIS INITIAL?	YES	NO	IF "NO", REASON FOR REPLACEMENT	DATE PRIOR PLACEMENT MO. DAY YEAR

CHECK ONE ☐ DENTIST'S PRETREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES	(WORK COMPLETED – PAYMENT REQUESTED) THE TREATMENT LISTED BELOW WAS COMPLETED AND WAS NECESSARY IN MY JUDGMENT. DENTIST SIGNATURE DATE

EXAMINATION AND TREATMENT RECORD

DATE FIRST VISIT (CURRENT SERIES) MO. DAY YEAR	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	NO. OF X-RAYS ETC.	ADA PROCEDURE NUMBER	DATE SERVICE PERFORMED MO. DAY. YEAR	FEE	ADMIN. USE ONLY
IDENTIFY MISSING TEETH WITH "X"								
								

PATIENT NAME

IF PARTIAL/DENTURE – INDICATE START DATE: _____ DELIVERY: _____

IF PROSTHESIS OR CROWN – INDICATE PREP DATE: _____ SEAT: _____

IF ROOT CANAL – INDICATE START DATE: _____ FINISH: _____

I HEREBY AUTHORIZE PAYMENT OF THE GROUP HEALTH BENEFITS DIRECTLY TO THE ABOVE-NAMED DENTIST, OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

EMPLOYEE SIGNATURE X _____ **DATE:** _____

SEE OTHER SIDE FOR INSTRUCTIONS

BENEFIT, CLAIMS PAYMENT AND ELIGIBILITY INFORMATION
MAY BE OBTAINED FROM:
WELFARE & PENSION ADMINISTRATION SERVICE, INC.
PHONE: (206) 441-7574 or (866) 986-1515
www.ironworkerstrust.com
claimstatus@wpas-inc.com