PLAN 33D DENTAL CLAIM

PUGET SOUND ELECTRICAL WORKERS HEALTH AND WELFARE TRUST

EMPLOYEE STATEMENT													
☐ Check here if your address is new. PART 1 - EMPLOYEE INFORMATION													
EMPLOYEE'S NAME - First	Initial	Last		□ M EMI	LOYEE SOCIAL SECURITY NUMBER			EMPLOYEE BIRTHDATE Mo. Day Ye			ATE Year		
HOME ADDRESS STREET	CITY		STATE ZIP			PHONE							
EMPLOYED BY								LOCAL NO	-				
PATIENT'S NAME - First	Initial	Last	☐ M PATIENT S	OCIAL SEC.	. NO.		BIRTH DATE Day Year	RELATION TO EMPLOYEE Self Spouse Child					
EMPLOYEE MARITAL STATUS ☐ MARRIED ☐ LEGAL	RELATIONSHIP T	UOY C	IILD, PLEASE INDICA		FULL-TIME STUDENT?								
☐ SINGLE SEP. ☐ WIDOWED ☐ DIVORCED	☐ NATURAL CHILD ☐ STEP CHILD ☐ OTHER (EXPLA	☐ GUARD	ANSHIP	ER CHILD	D □ YES □ NO NAME OF SCHOOL						:		
NAME OF SPOUSE (if not patient li	sted above)				SPOUSE I	BIRTHDATE	SPOUSE SOC	CIAL SECURI	TY NO.				
IS SPOUSE EMPLOYED? NAME & ADDRESS SPOUSE'S EMPLOYER ☐ YES ☐ NO													
PART 2 - INSURANCE INFORMATION													
ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? YES NO													
IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER													
NAME OF SUBSCRIBER	SUBSCF	_ SUBSCRIBER SOC. SEC. NO											
OTHER GROUP PLAN COVERS:	☐ PATIENT	SPOUSE	☐ CHILDREN	OTHER (GROUP PLA	IN POLICY OF	R I.D.#						
OTHER GROUP PLAN INCLUDES:		\square DENTAL	□ VISION										
ARE YOU OR YOUR DEPENDENTS	COVERED UNDER	R MEDICARE?	☐ YES ☐ NO										
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 DISABILITY.													
EMPLOYEE'S SIGNATU	RE 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:

P.S.E.W. TRUST P.O. Box 34970 Seattle, WA 98124-1970

Phone: (206) 441-7574 or 1-800-331-6158

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.

PART 3 - DENTIST INFORMATION															
DENTIST NAME	IS PATIENT COVERED BY ANOTHER PLAN? IF "YES", ENTER NAME OF OTHER PLAN							YES	3	NO					
DENTIST MAILING ADDRESS															
DENTIST CITY, STATE, ZIP						IS ANY OF THE TREATMENT FOR ORTHODONTIC PURPOSES?									
, ,						TREATMENT RESULT OF ACCIDENT?									
YOUR TAX IDENTIFICATION NUMBER	RESULT OF OCCUPATIONAL INJURY?														
OTHER WISE, YOUR SOC. SEC. NUMBER						ARE X-RAYS ENCLOSED?									
(MUST BE FURNISHED UNDER AUTHORITY OF LAW)						IF "YES", HOW MANY?									
IF PROSTHESIS, IS THIS INITIAL?	NO IF "NO", REASON FOR REPLACEMENT DATE PRIOR I MO.							PLACEMENT DAY YEAR							
CHECK ONE	(WORK COMPLETED - PAYMENT REQUESTED)														
☐ DENTIST'S PRETREATM	THE TREATMENT LISTED BELOW WAS COMPLETED AND WAS NECESSARY IN MY JUDGMENT.														
☐ DENTIST'S STATEMENT	DENTIST														
	SIGNATURE DATE														
EXAMINATION AND TREATMENT RECORD										DATE				۸۲	MINI
DATE FIRST VISIT (CURRENT SERIES) MO. DAY YEAR	TOOTH DESCRIPTION OF SERVI			LAXIS X-RAYS PROCEDURE			DATE SERVICE PERFORMED FEE				ADMIN USE ONLY				
		MATERIALS USED, ETC)	ETC.	NUMBER	MO.	DAY	YEAR				
IDENTIFY MISSING TEETH WITH "X"															
Facial															
2000,000															
C Lingual H 14															
l Jed															
ddn Right		-													
nent ary															
M. M. M.															
R Lingual M 19															
27 25 24 23 60		1													
	IF PARTIAL/DENTURE - INDICATE START DATE: DELIVERY:														
Facial	IF PROSTHESIS OR CROWN - INDICATE PREP DATE: SEAT:														
	IF ROOT CANAL - INDICATE START DATE: FINISH:														
	I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST OF THE GROUP DENTAL BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY DESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS ALITHOPIZATION.														
PATIENT NAME	RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION. ATIENT NAME														
EMPLOYEE SIGNATURE X DATE															

SEE OTHER SIDE FOR INSTRUCTIONS