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 ______________

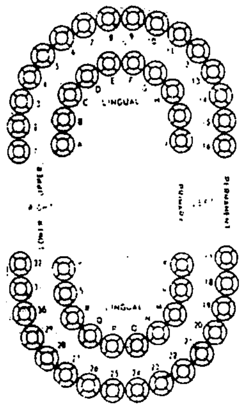
I hereby authorize payment directly to the below-named dentist of the Group Insurance Benefits otherwise payable to me.

Signed (Insured Person) ______________ Date ______________

		No	Yes	If Yes, enter brief description and dates
16. Dentist Name	24. Is treatment result of occ. illness or injury?			
17. Mailing Address	25. Is treatment result of Auto Ac.			
	26. Other accident?			
City, State, Zip	27. Are any serv. covered by another plan?			
18. Dentist (Soc. Sec. or T.I.N.) 19. Dentist Lic. No. 20. Dentist Phone No.	28. If prosthesis, is this initial placement?			(If no, reason for replacement) 29. Date of prior placement
21. First Visit Date Current Series; 22. Place of Treatment: Office / HOSP / ECF / Other; 23. Radiographs or Models enclosed? No / Yes / How Many?	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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32. Remarks for unusual services.

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

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

Signed (Dentist) ______________ Date ______________

TOTAL FEE CHARGED	
Max. Allowable	