

# MO-KAN SHEET METAL WORKERS WELFARE FUND

## DENTAL INSURANCE CLAIM FORM

PRE-AUTHORIZATION REQUIRED ON ALL TREATMENT PLANS EXCEEDING \$250.00

CLAIM INSTRUCTIONS ARE SHOWN ON REVERSE SIDE OF FORM

**CHECK ONE:**     DENTIST'S PRE-TREATMENT ESTIMATE     DENTIST'S STATEMENT OF ACTUAL SERVICES

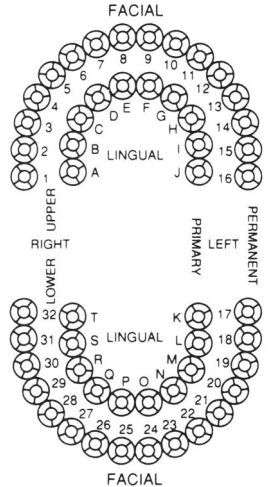
### SECTION 1: EMPLOYEE'S INFORMATION

1. PATIENT NAME			2. RELATIONSHIP TO EMPLOYEE SELF   SPOUSE   CHILD   OTHER				3. SEX M   F		4. PATIENT BIRTHDATE MO   DAY   YEAR			5. FULL TIME STUDENT SCHOOL
6. EMPLOYEE/SUBSCRIBER NAME FIRST   MIDDLE   LAST		7. MO-KAN ID#		8. MEMBER BIRTHDATE MO   DAY   YEAR								
9. EMPLOYEE/SUBSCRIBER MAILING ADDRESS						11. EMPLOYER (COMPANY) NAME AND ADDRESS						
10. CITY, STATE, ZIP												
12. ARE OTHER FAMILY MEMBERS EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		13. IF YES, NAME OF EMPLOYER		14. SOCIAL SECURITY NO.		15. NAME AND ADDRESS OF EMPLOYER IN ITEM 11			16. PHONE NO.			
17. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO			DENTAL PLAN NAME		GROUP NO.		NAME, ADDRESS AND AND PHONE NUMBER OF CARRIER					

18. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.				19. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.			
PATIENT'S SIGNATURE _____				SIGNED (INSURED PERSON) _____			
EMPLOYEE'S SIGNATURE _____				DATE _____			

### SECTION 2: DENTIST'S INFORMATION

20. DENTIST NAME			28. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES				
21. MAILING ADDRESS			29. IS TREATMENT RESULT OF AUTO ACCIDENT?								
22. CITY, STATE, ZIP			30. OTHER ACCIDENT?								
23. DENTIST SOC SEC OR TIN			24. DENTIST PHONE NO.		32. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		(IF NO, REASON FOR REPLACEMENT)		DATE OF PRIOR PLACEMENT		
25. FIRST VISIT DATE CURRENT SERIES		26. PLACE OF TREATMENT OFFICE   HOSP.   ECF   OTHER		27. RADIOGRAPHS OR MODELS ENCLOSED?		NO	YES	HOW MANY?		33. IS TREATMENT FOR ORTHODONTICS?	
										IF SERVICES ALREADY COMMENCED ENTER	
										DATE APPLIANCES PLACED	
										MOS TREATMENT REMAINING	

IDENTIFY MISSING TEETH WITH AN "X" 		34. EXAMINATION AND TREATMENT PLAN-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32										
		TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO.   DAY   YEAR	PROCEDURE NUMBER	CHARGES	MO KAN USE ONLY USUAL AND CUSTOMARY ALLOWANCES				
35. REMARKS FOR UNUSUAL SERVICES												

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.							TOTAL FEE CHARGED	
SIGNED (INSURED PERSON) _____						DATE _____		

**MO-KAN SHEET METAL WORKERS WELFARE FUND**

Mail Claims for Payment to:  
P.O. Box 25938  
Shawnee Mission, KS 66225-5938

Mail Pretreatment Estimates & Ortho Claims to:  
P.O. Box 30019  
Kansas City, MO 64130-0019  
(816) 531-0334 OR 1-8696-531-5488

DEDUCTIBLE	
BALANCE	
CO-INSURANCE	
BENEFIT	

## INSTRUCTIONS

### FOR THE EMPLOYEE:

COMPLETE IN FULL THE EMPLOYEE'S INFORMATION SECTION. ANY OMISSIONS MAY REQUIRE THAT THE FORM BE RETURNED TO YOU.

IF YOU WISH BENEFITS ASSIGNED TO YOUR DENTIST, PLEASE DATE AND SIGN. ASSIGNED BENEFITS WILL BE SENT TO YOUR DENTIST. A COPY OF THE PAYMENT VOUCHER WILL BE SENT TO YOU. BENEFITS NOT ASSIGNED WILL BE PAID DIRECTLY TO YOU.

GIVE THE CLAIM FORM TO YOUR DENTIST AND HE WILL COMPLETE THE DENTIST'S INFORMATION SECTION.

### **ADDITIONAL FORMS MAY BE OBTAINED FROM YOUR FUND OFFICE OR LOCAL UNION.**

COMPLETE THE DENTIST'S SECTION TWO INFORMATION AND MAIL THIS FORM TO THE ADDRESS SHOWN ON THE REVERSE SIDE OF THIS FORM.

### FOR THE DENTIST:



NOTE: IF YOUR TREATMENT PLAN INVOLVES TOTAL CHARGES IN EXCESS OF THE AMOUNT SHOWN ON THE UPPER LEFT OF THE REVERSE SIDE OF THIS FORM, PRE-AUTHORIZATION IS REQUIRED. FOR PRE-AUTHORIZATION, SUBMIT ESTIMATE TO THE FUND OFFICE, ADDRESS IS ON FRONT OF CLAIM FORM. THE ORIGINAL ESTIMATE WILL BE RETURNED TO YOU SHOWING THE AMOUNT OF BENEFITS PAYABLE. ANY X-RAYS SUBMITTED WILL BE RETURNED TO YOU. WHEN TREATMENT IS COMPLETED, INDICATE THE DATES OF SERVICE IN THE COLUMN PROVIDED, SIGN AND DATE THE FORM AND MAIL THE FORM TO:

P.O. Box 25938  
Shawnee Mission, KS 66225-5938

AN ASSIGNMENT IS INCLUDED ON THE TOP PORTION OF THE CLAIM FORM.

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIALLY THERETO, COM- MITTS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.**

### **IMPORTANT NOTICE**

**PRE-AUTHORIZED BENEFITS WILL BE PAID PROVIDED THE PATIENT IS ELIGIBLE FOR COVERAGE AT THE TIME THE SERVICE IS PERFORMED.**