## ATTENDING DENTIST'S STATEMENT - INSURANCE CLAIM

## **NO PRE-ESTIMATES**

## **SEND COMPLETED FORM TO:**

## IRON WORKERS BENEFIT TRUST MAIN P.O. BOX 398 • DAYTON, OHIO 45401-0398 PHONE: 1-800-331-4277 • FAX: 1-937-454-5457

1. IRON WORKER'S NAME				2. SOCIAL SECURIT	3. IRON WORKERS BEN	LOCAL#						
4. IRON WORKER'S MAILING ADDRESS						5.						
7. CITY, STATE, ZIP						BON WORKER'S BIRTHDAY SPOUSE BIRTHDAY  8. AUTHORIZED SIGNATURE BY BENEFIT PLAN OFFICE						-
							<b></b>		· · ·			
9. PATIENT NAME 10. PATIENT RELATIONSHIP TO IRONWORKER						11. PATIENT BIR' MONTH DAY	THDAY YEAF	3	12. PATIE	NT S.S. #		
13. DENTIST NAME 14. LICENSE NO.						15. IS PATIENT COVERED BY OTHER PLAN? (NAME OTHER PLAN)					YES	NO
16. DENTIST MAILING ADDRESS 17. PHONE NUMBER  18. IS ANY OF TREATMENT FOR ORTHODONTIC PURPOSES										JRPOSES?		
9. CITY 20. TREATMENT RESULT OF ACCIDENT? STATE 21. RESULT OF OCCUPATIONAL INJURY?												
22. DENTIST FEDERAL I.D. #	23. IF PROTI IS THIS II PLACEM	NITIAL	ITIAL FOR REPLACEMENT			DATE OF PRIOR PLACEMENT	E X-RAYS ENC YES, HOW MA					
IMPORTANT — IRC	N WORKE	R MUST	ГСОМР	LETE THIS SECTI	ON BE	FORE TAKING T	HIS	ORM	TO DENT	IST		
ARE OTHER FAMILY MEMBE	RS COVERED U	JNDER AN	OTHER DEN	TAL PLAN ?	NAM	ME AND ADDRESS OF EM	IPLOYE	:R				-
☐ YES ☐ NO  IF YES, NAME OF FAMILY MEMBER SOC. SEC. NO.						SURANCE COMPANY NAME, ADDRESS AND PHONE NUMBER						
		26. EXAM	IA NOITANIN	ND TREATMENT RECORD	 	N ORDER FROM TOOTH	NO. 1 TI	HROUGI	1 TOOTH NO 3	2		
<b>60000</b>	TOOTH # OR LETTER SURFACES (Including X-Rays, Prophylaxis							PROCEDURE NUMBER	DEDURE EEE		DO NOT USE THIS	
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INDICATE MISSING	TEETU	ļ					$\perp \! \! \perp$					
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Notice: Any person,								+-				
intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an				2:30	,	* * **** - ***************************			TOTAL FEE ACTUALLY CHARGED	<u> </u>		
application or files a	a claim		IEFITS AF	RE PAID TO THE PRO	VID <u>ER</u> I	UNLESS A PAID IN I	ULL	RECEI	PT IS ATTAC	HED TO T	HIS FO	PRM.
containing a false o deceptive statemen		LHERE	BY ACCEPT	THE FOREGOING TREAT	MENT PI	AN AND AUTHORIZE REI	FASE	OF ANY	INFORMATION	I RELATING	TO THIS	CLAIM
of insurance fraud.			ORKER'S SI	•		· · · · · · · · · · · · · · · · · · ·				_ DATE _		
	<b>,</b>	I HEREI	BY CERTIFY	THAT THE SERVICES LIS	STED ABO	OVE HAVE BEEN PERFOR	RMED.					

DENTIST SIGNATURE.



DATE \_