STONE AND MARBLE MASONS OF METROPOLITAN WASHINGTON, D.C.
HEALTH & WELFARE FUND

PHONE
(410) 872-9500

7130 Columbia Gateway Drive, Suite A, Columbia, Maryland 21046

DENTAL CARE CLAIM FORM

[redacted]

Type or Print

1. **Social Security Number**

2. **Employee's Name** (Last, First and Middle)

3. **Employee's Address** (Street, City, State and Zip Code)

4. **Patient's Name** (Last, First and Middle)

5. **Patient's Birthdate** Mo. | Day | Year

6. **Patient's Relationship to Subscriber** (Check Appropriate Box)

Male: ☐ Self (1) ☐ Spouse (3) ☐ Son (5)

Female: ☐ Self (2) ☐ Spouse (4) ☐ Daughter (6)

7. **Employer**

8. **Is the patient covered under another Dental Benefits Plan?** ☐ **Yes** ☐ **No** **If yes: carrier name**

policy holder _____ **policy number** _____ **effective date** _____ **Individual** ☐ **Family** ☐

9. **Is treatment a result of injury?** ☐ Yes ☐ No If yes, date of injury _____ If yes, did injury occur on the job? ☐ Yes ☐ No **Worker's Compensation**

10. **I certify that the above information is correct and apply for benefits under my dental coverage with the plan. I authorize any dentist or physician in possession of information concerning the patient to furnish such information to the Plan upon request.**

11. **Assignment of Benefits** ☐ **Yes** ☐ **No**

If answer is yes sign again

[redacted] Signature of Employee — Date — Signature of Employee

Type or Print

12. **If prosthesis, is this initial placement?** ☐ Yes ☐ No — Date of original prosthesis — Reason for replacement

13. **Is orthodontic treatment included in the services listed below?** ☐ Yes ☐ No
Is this initial treatment? ☐ Yes ☐ No

14. **X-ray or models enclosed?** ☐ Yes ☐ No

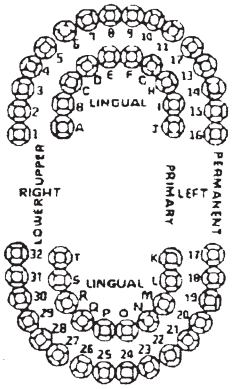
15. **For services involving missing teeth, indicate tooth number and date tooth was lost or extracted:**

Tooth _____ **Date** _____ **Tooth** _____ **Date** _____ **Tooth** _____ **Date** _____ **Tooth** _____ **Date** _____

[redacted] **Date** _____ **Tooth** _____ **Date** _____ **Tooth** _____ **Date** _____

IDENTIFY MISSING TEETH WITH AN "X" FOR ALL SUBMISSIONS

FACIAL



16. Description of Services (For description of unusual services, see reverse side)

Tooth No. or Letter	Surfaces	Detailed description of services including x-rays (show quantity, materials, etc.)	Date of Service M	D	Y	A D A Procedure Code	Total Chg Each Serv	No. of Times Perf	Teeth or Range						Elig.	Act.	Reproc Code	Alt. Proc Code
						Total												

☐ _____ **PREDETERMINATION OF BENEFITS** _____
The treatment listed is necessary in my professional judgement and I request **Predetermination of Benefits.**

☐ _____ **WORK COMPLETED—PAYMENT REQUESTED** _____
I certify that the above services have been performed by me or under my personal supervision and are necessary in my professional judgment. Charges shown are my usual charges.

Dentist's Signature

Dentist's Name

Address

City **State** **Zip Code**

Tax Paying ID No.