

DENTAL BENEFITS CLAIM FORM

JOINT WELFARE FUND - LOCAL 164

RETURN COMPLETED FORM TO:

FABIAN & BYRN LLC
 204 Eagle Rock Avenue
 Second Floor
 Roseland, NJ 07068
 Tel: (973) 228-4200
 Fax: (973) 228-4240

IMPORTANT: PLEASE BE AWARE THAT IF AN ALTERNATIVE COVERED SERVICE CAN BE PERFORMED TO CORRECT A DENTAL CONDITION, THE BENEFIT PAYABLE WILL BE BASED ON THE ALLOWABLE CHARGE FOR THE LEAST EXPENSIVE COVERED SERVICE WHICH WILL PRODUCE A PROFESSIONAL RESULT AS DETERMINED BY OUR DENTAL CONSULTANTS, PROFESSIONAL DENTAL REVIEWERS, INC. (PDR). PROCEDURES SUBJECT TO THIS ALTERNATE BENEFIT PROVISION ARE BRIDGES, DENTURES, CROWNS, INLAYS/ONLAYS, FILLINGS AND PERIODONTAL PROCEDURES. THESE CLAIMS, OR ANY CLAIM EXCEEDING \$300, SHOULD BE SENT TO THE FUND OFFICE FOR A PREDETERMINATION OF THE SERVICES AND AMOUNTS TO BE REIMBURSED.

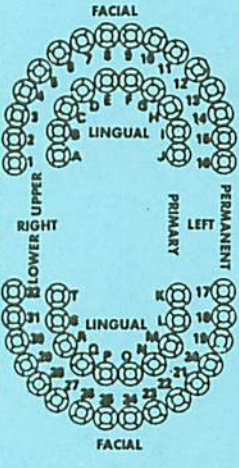
PATIENT INFORMATION

1. PATIENT NAME (FIRST MIDDLE INITIAL LAST)			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 NAME FIRST MIDDLE INITIAL LAST			7. EMPLOYEE SOCIAL SECURITY NO.			9. EMPLOYEE'S EMPLOYER					
8. EMPLOYEE ADDRESS CITY STATE ZIP PHONE NO.						10. EMPLOYER ADDRESS					
11. GROUP NUMBER		12. LOCATION (LOCAL)		13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME SOC. SEC. NO. IF YES			14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13				
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YES, GIVE			GROUP NAME UNION LOCAL GROUP NO.		NAME AND ADDRESS OR PROVIDER OF BENEFITS						

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OR ANY INFORMATION NECESSARY TO PROCESS THIS REQUEST. _____ SIGNED (PATIENT OR PARENT IF MINOR) DATE	I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST FOR THE SERVICES DESCRIBED BELOW. _____ SIGNED (EMPLOYEE OR AUTHORIZED PERSON) DATE
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DENTIST'S INFORMATION

16. DENTIST NAME				24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES			
17. MAILING ADDRESS CITY, STATE, ZIP				25. IS TREATMENT RESULT OF AUTO ACCIDENT?							
18. DENTIST SOC. SEC. OR T I N				19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		26. OTHER ACCIDENT?			
21. FIRST VISIT DATE CURRENT SERIES				22. PLACE OF TREATMENT OFFICE HOSP. ECP. OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?		27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?				29. DATE OF PRIOR PLACEMENT		(IF NO, REASON FOR REPLACEMENT)					
30. IS TREATMENT FOR ORTHODONTICS?				IF SERVICES ALREADY COMMENCED. ENTER		DATE APPLIANCES PLACED		MOS. TREATMENT REMAINING			

IDENTIFY MISSING TEETH WITH X 	31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1. THROUGH TOOTH NO. 32. - USE CHARTING SYSTEM SHOWN.						FOR ADMINISTRATIVE USE ONLY	
	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO. DAY YEAR		PROCEDURE NUMBER		
	32. REMARKS FOR USUAL SERVICES							

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED _____ SIGNED (DENTIST) DATE	TOTAL FEE CHARGED Plan Maximum Payable Now	
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