STATEMENT OF CLAIM FOR GROUP DENTAL BENEFITS

RETURN COMPLETED FORM TO:

GREATER KANSAS CITY LABORERS WELFARE FUND
6405 Metcalf, Suite 200
Overland Park, Kansas 66202
(913) 236-5490

Please check if new address ❑

MEMBER MUST COMPLETE THIS SECTION IN FULL

Member's Full Name	Member's Martial Status: M / S / Wid. / Div. / Leg. / Sep.	❑ Male ❑ Female	Date of Birth	Social Security No.
Home Address (Number and Street)	(City)	(State)	(Zip Code)	Telephone No.
Patient's Full Name	Patient's Martial Status: M / S / Wid. / Div. / Leg. / Sep.	❑ Male ❑ Female	Date of Birth	Relationship to Member
Was there an accident? ❑ Yes ❑ No	Date accident occurred	Time: ❑ A.M. ❑ P.M.	Was patient at work when the injury/ accident occurred? ❑ Yes ❑ No	

Describe accident (Tell how, when and where it occurred)

Is this patient covered under any other group health plan? _____ Yes _____No Effective Date _____

Is this patient covered under Medicare? _____Yes _____ No Effective Date _____

Name of Insured _____

Name of group (employer or union) through which coverage is provided _____

Name and address of the office where claims are paid _____

_____

The policy or identification number _____

NOTE: Attach copy of payments made by other company.

TO BE SIGNED BY MEMBER IF BENEFITS ARE TO BE PAID TO THE DOCTOR

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the hospital or physician of the benefits, if any, otherwise payable to be for services as described but not to exceed the reasonable and customary charge for those services.

SIGNED (Eligible Member) Date

I here by certify the above statements are true and complete to the best of my knowledge and belief. I authorize any physician, hospital, insurer or other organization or person having any records, data or information concerning me or my dependents to furnish such records, data or information as may be requested by such company to the Laborers Welfare Plan. I understand that in executing this authorization, I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

MEMBER'S SIGNATURE

REMEMBER TO ATTACH ITEMIZED BILL

Signed _____

Address/City _____

Dated _____

A CLAIM FORM MUST BE FILED FOR EACH INJURY OR ILLNESS

ATTENDING DENTIST'S STATEMENT
INSURANCE CLAIM
Uniform Report Form

Forward completed form to:
address on reverse side

LABORERS

PATIENT	PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT BIRTHDATE (MO-DAY-YR)

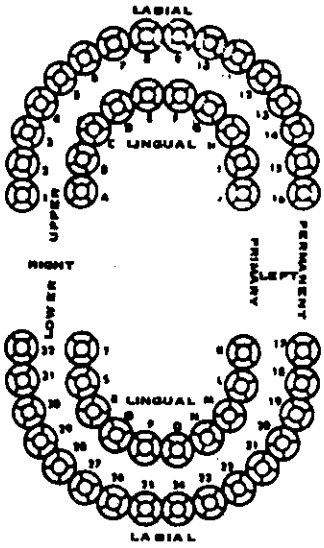
DENTIST NAME	SOC. SEC. - IRS NO.	IS PATIENT COVERED BY OTHER PLAN? (NAME OTHER PLAN)	YES	NO

DENTIST MAILING ADDRESS	PHONE	IS ANY OF TREATMENT FOR ORTHODONTIC PURPOSES?		

CITY	STATE	ZIP	TREATMENT RESULT OF ACCIDENT?		
			RESULT OF OCCUPATIONAL INJURY?		

IS THIS CLAIM FOR:
Pre-Treatment Estimate ☐
Final Statement of Services Rendered ☐

A pre-treatment estimate does not guarantee payment on this claim. Payment will be made if member is eligible for the Plan on date(s) treatment is rendered.



* INDICATE MISSING TEETH WITH AN 'X'

26. Remarks for unusual services.

Examination and treatment record - List in order from Tooth No. 1 through Tooth No. 32

Tooth No. or Letter	Surfaces	Description of Service (Including X-Rays, Prophylaxis, Materials Used, etc.)	Date Service Performed	Procedure No.	Fee	DO NOT USE THIS COLUMN
				Total Fee Actually Charged		

TOTAL FEE.....$ _____

I hereby accept the foregoing treatment plan and authorize release of any information relating to this claim.

Insured/
Member's
Signature _____

I hereby certify that the services listed above have been performed.

Dentist
Signature _____ Date _____