Alaska Pipe Trades Association - U.A. Local No. 375
Health and Security Trust Fund
Dental/Vision Member Reimbursement Claim Form

PO Box 1618
San Ramon, CA 94583
Phone: (503) 535-6851 or (800) 811-8851 **Fax:** (503) 228-0149
Email: SHARED_PORTLANDAIBCLAIMS@benesys.com

Information Required for Processing:

- ✓ Itemized bill reflecting proof of payment
- ✓ Provider's name, address, phone number & Tax ID
- ✓ Procedure Code (CPT) and Diagnosis Code (ICD) for Vision Claims
- ✓ Current Dental Terminology (CDT) codes for Dental Claims
- ✓ Cash register receipts alone are not acceptable

Member's Name: _____

Member's DOB: _____ Alt ID or Last 4 SSN: _____

Address: _____

Phone Number: (Home) _____ (Work) _____ (Cell) _____

Patient Name: _____ Patient's DOB: _____

Provider's Name: _____ Tax Id: _____

Provider's Address: _____

Provider's Phone #: _____

CPT/CDT: _____ _____ _____ _____

ICD: _____ _____ _____ _____

Date of Service	**Provider**	**Billed Amount**

Member's Signature: _____ Date: _____