

DENTAL PLAN BENEFITS

I.B.U. NATIONAL HEALTH BENEFIT PLAN
 PMB #116 · 5331 SW Macadam Avenue Suite 258
 Portland, OR 97239
 Portland Area: (503) 224-0048 All Other Locations: (800) 547-4457

PART 1: MUST BE COMPLETED BY EMPLOYEE

1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH		3. EMPLOYEE'S NAME, ADDRESS AND PHONE NO.	
FULL TIME STUDENT YES NO IF YES, WHERE					
4. PATIENT'S ADDRESS (if different from employee)		5. PATIENT'S SEX MALE FEMALE		6. EMPLOYEE'S SOC. SEC. NO.	
9. IS PATIENT ALSO COVERED BY ANOTHER GROUP HEALTH PLAN? YES NO If Yes, List Plan Name, Employer and Address		7. PATIENT'S RELATIONSHIP SELF SPOUSE CHILD OTHER		8. EMPLOYER LOCATION	
		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES NO B. AN ACCIDENT YES NO		11. IF AN ACCIDENT €A.M. date _____ 20__ and time _____ P.M. description (how & where) _____	

12. AUTHORIZATION TO RELEASE INFORMATION 13. AUTHORIZATION TO PAY BENEFITS TO PROVIDERS

PATIENT OR PARENT RELEASE SIGN BELOW I hereby authorize any insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. X _____ DATE _____ PATIENT OR PARENT (IF MINOR)		IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW I hereby authorize payment of benefits directly to any providers of services, but not to exceed the usual, reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization. X _____ DATE _____ EMPLOYEE	
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PART 2: TO BE COMPLETED BY PHYSICIAN (OR ATTACH ITEMIZED BILL)

14. Dentist Name		22. Is Treatment Result of Occupational Illness or injury?		Yes	No	If yes, Enter Brief Description & Dates			
15. Mailing Address		23. Is Treatment Result Of Auto Accident							
City, State, Zip		24. Other Accident							
16. Dentist (Soc. Sec or T.I.N)		17. Dentist Lic. No.		18. Dentist Phone No.		25. Are any Services covered by another Plan?			
19. First visit date Current Series	20. Place of Treatment	21. Radiographs or Models Enclosed?	No	Yes	How Many?	26. If Prosthesis, Is this initial Placement	(If no, Reason for Replacement)	27. Date of Prior Placement	
						27. Is this Treatment for Orthodontics	28. If service already commenced Enter	Date Appliance Placed	Mos. Treatment Remaining?

Indicate missing teeth WITH "X" 	Examination and Treatment Plan – LIST IN ORDER NO 1 THROUGH TOOTH NO 32 – USE CHARTING SYSTEM SHOWN			32 Date Service Performed			Procedure Number		Fee		For Administrative Use Only	
	Tooth # or Let.	Surface	Description of Service (Including X-Rays, Prophylaxis, Material Used Etc)	MO	DA	YR						
30. Remarks for Unusual Services												

I hereby certify that The Procedures As Indicated By Date Have Been Completed								Total Fee Charged		
Signed (Dentist) _____ Date _____								Max. Allowable		
								Deductible		
								Carrier %		
								Carrier Pays		
								Patient Pays		

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HOW TO REQUEST BENEFITS

1. COMPLETE THE “PATIENT INFORMATION” (ITEMS 1 THROUGH 12) ON THE ABOVE FORM.

If you wish your dental benefits paid directly to your dentist sign item 13.

2. HAVE YOUR DENTIST COMPLETE THE “DENTIST OR SUPPLIER INFORMATION”.
3. ATTACH THE COMPLETED “BENEFIT REQUEST FORM” TO THE BILLS AND MAIL THEM TO THE PLAN ADMINISTRATOR AT THE FOLLOWING ADDRESS BELOW.
4. A SEPARATE FORM MUST BE SUBMITTED FOR EACH FAMILY MEMBER FOR WHOM A CLAIM FOR BENEFITS IS BEING MADE.

WHERE TO FILE A CLAIM:

INLANDBOATMEN’S UNION NATIONAL HEALTH TRUST

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CHECK YOUR ELIGIBILITY – CALL THE ADMINISTRATION OFFICE

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