

**OHIO BRICKLAYERS HEALTH and WELFARE FUND**  
**P.O. BOX 99550**  
**TROY, MICHIGAN 48099**  
**(248) 641-4921 or Toll Free (833) 289-4921**

B300

**Dental Insurance**  
**Claim Form**

**Instructions:** To receive reimbursement for qualified dental claims, you must complete **ONE FORM** per patient, along with the following information:

**Reimbursement for:**

Dental Services (\$200.00 annual maximum)

**Information Required:**

Copy of a detailed invoice listing the services rendered and the charge for each.  
**Cash register receipts are not acceptable.**

**PLEASE NOTE:** Once you have met your calendar year maximum benefit under the Plan, you may use your HRA to pay for any outstanding amounts due by submitting a properly completed HRA claim form. **You MUST allow up to 30 business days for reimbursement.** All reimbursements for claims will be made payable to the member. A claim for reimbursement must be filed within 365 days after it was incurred.

Member's SS#

Member's Name: \_\_\_\_\_ or alternate ID: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Patient Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Type of Service	Providers Name	Date of Service	Amount of Claim
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____

By signing this form, I understand that benefits shall be paid in accordance with the Ohio Bricklayers' Health and Welfare Fund's requirements and limitations established by the Board of Trustees. (See the reverse side of this form for a brief description of covered benefits).

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OVER**

## **DENTAL REIMBURSEMENT**

### **What is the Dental Care/ Pediatric Oral Care Benefit?**

The maximum annual (calendar year) benefit per person is \$200.

\*This benefit is NOT subject to the Deductible or Coinsurance

For pediatric patients only (children up to age 18), the \$200 annual maximum for dental services/pediatric oral care does not apply. Note, that orthodontics is not covered under this dental/pediatric oral care benefit.

### **How do I Request Reimbursement for Dental Services?**

You must send a completed Dental Insurance Claim Form along a copy of a detailed invoice listing the services rendered and the charge for each. Cash register receipts and balance due statements are not acceptable.

### **What if I Have Met my Annual Maximum for Dental Services?**

If you, or your dependents, have met the maximum annual (calendar year) benefit allowable under the plan, you may request reimbursement from your HRA for additional qualified expenses. **You must submit a separate HRA claim form, with the appropriate documentation, in order to receive reimbursement from your HRA.**

### **Information Required**

A copy of a detailed invoice listing the services rendered and the charge for each. Cash register receipts are not acceptable.

### **Where do I Obtain a Dental Insurance Claim Form?**

You may call the Fund Office to have a Claim Form mailed to you, or you may download one from the participant website: [www.ourbenefitoffice.com/Ohiobrick/Benefits/HealthcareDocuments.aspx](http://www.ourbenefitoffice.com/Ohiobrick/Benefits/HealthcareDocuments.aspx)

### **Where do I send my Dental Insurance Claim Form?**

Send these requests to:

Ohio Bricklayers' Health and Welfare Fund  
Dental Insurance Claims  
P.O. Box 99550  
Troy, MI 48099