APWU HEALTH PLAN

P. O. BOX 1358 GLEN BURNIE, MD 21060
PHONE: 1-800-222-APWU

(CARRIER USE ONLY)

DENTIST CLAIM FORM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. INSURED'S ID NUMBER

2. INSURED'S NAME & ADDRESS

(IF ADDRESS INCORRECT, PLEASE CORRECT ABOVE)

3. PATIENT (CHECK PATIENT'S NAME: ONLY ONE PATIENT PER CLAIM FORM)

☐ ENTER FIRST NAME (IF NOT LISTED ABOVE) _____

(PLEASE ADVISE THE HEALTH PLAN IF THIS LISTING IS INCORRECT)

4. PATIENT'S DATE OF BIRTH

5. PATIENT'S SEX: ☐ MALE ☐ FEMALE

6. IS PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE? ☐ YES ☐ NO
IF YES, **PLEASE INDICATE NAME OF POLICYHOLDER**, PLAN NAME, ADDRESS, POLICY NO. AND PHONE NO. IF NO, PLEASE SIGN AND DATE.

IF YES, PLEASE ATTACH PAYMENT STATEMENT FROM OTHER CARRIER.

7. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO
IF YES, INDICATE FILE NO. _____
B. AN AUTO/MOTORCYCLE ACCIDENT? ☐ Yes ☐ No

IF YES, PLEASE ATTACH PAYMENT STATEMENT.

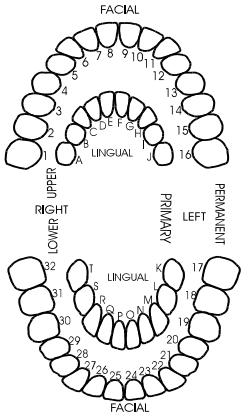
8. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE AUTHORIZING THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.
SIGNED: DATE:

9. ASSIGNMENT OF BENEFITS: I OR MY SPOUSE HEREBY AUTHORIZE PAYMENT OF BENEFITS TO THE UNDERSIGNED PROVIDER.
SIGNED: DATE:

DO NOT SEND X-RAYS OR MODELS. IF NEEDED, PLAN WILL REQUEST THEM.
EXAMINATION AND TREATMENT RECORD — USE CHARTING SYSTEM SHOWN

(CHECK ONE) DENTIST'S ☐ **PRE-TREATMENT ESTIMATE** ☐ **ACTUAL SERVICES**

IDENTIFY MISSING TEETH WITH "X"



TOOTH NO. OR LETTER	SURFACES	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis Materials used, etc.)	DATE SERVICES PERFORMED MO/DAY/YR	ADA PROCEDURE NUMBER	FEE	FOR CARRIER USE ONLY

TOTAL CHARGE		
PATIENT PAID		
BALANCE		

Diagnosis _____

Were services the result of accidental injury? ☐ Yes ☐ No Give Date of Accident _____

Give descriptive number of ALL teeth injured _____

How and where did it occur? _____

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insurance subscriber)
48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN

52. Phone Number ( ) -	52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____ _____
Signed (Treating Dentist) Date

54. NPI	55. License Number

56. Address, City, State, Zip Code	56A. Provider Specialty Code

57. Phone Number ( ) -	58. Additional Provider ID

SEE REVERSE SIDE FOR CLAIMS FILING INSTRUCTIONS

CLAIMS FILING INSTRUCTIONS

FOR THE PATIENT:

1. Please fill out the top half of this form. See items 1-9.
2. If you want your APWU Health Plan to send a check directly to your dentist, please sign and date the assignment of benefits section which appears in item 9. **DO NOT SIGN** this block if you want to receive payment.
3. Claims must be submitted by December 31 of the year after the year you received the service. Failure to file within this limit will invalidate your claim.

FOR THE PROVIDER:

1. Please complete the bottom half of this form.
2. Please show a description and an ADA Code for each service. Non coded claims may be returned unpaid.
3. Please include your Federal Tax Identification number and your National Provider Identification number **OR A PAYMENT DELAY MAY RESULT.**
4. **DO NOT SEND X-RAYS. THEY WILL NOT BE RETURNED TO YOU.**

MAIL CLAIMS TO:

APWU Health Plan
P. O. Box 1358
Glen Burnie, MD 21060