

# Pipe Industry Health and Welfare Fund of Colorado

EMPLOYEE STATEMENT							
<input type="checkbox"/> Check here if your address is new							
<b>PART 1 – EMPLOYEE INFORMATION</b>							
EMPLOYEE'S NAME – First		Initial	Last	<input type="checkbox"/> M <input type="checkbox"/> F	WPAS ID # OR SOCIAL SECURITY NO.	EMPLOYEE BIRTHDATE Mo. Day Year	
HOME ADDRESS	STREET	CITY		STATE	ZIP	PHONE	
PATIENT'S NAME – First		Initial	Last	<input type="checkbox"/> M <input type="checkbox"/> F	PATIENT ID OR SOCIAL SECURITY NO.	PATIENT BIRTHDATE Mo. Day Year	RELATION TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
EMPLOYEE MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED			IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> ADOPTED CHILD				
NAME OF SPOUSE (if not patient listed above)				SPOUSE BIRTHDATE Mo. Day Year		SPOUSE ID # OR SOCIAL SECURITY NO.	
IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME & ADDRESS SPOUSE'S/DOMESTIC PARTNER'S EMPLOYER						
<b>PART 2 – INSURANCE INFORMATION</b>							
ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO							
IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER    NAME _____    ADDRESS _____							
NAME OF SUBSCRIBER _____    SUBSCRIBER ID OR SOCIAL SECURITY NO. _____							
OTHER GROUP PLAN COVERS: <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN    OTHER GROUP PLAN POLICY OR I.D. NO. _____							
OTHER GROUP PLAN INCLUDES: <input type="checkbox"/> DENTAL							
THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY AUTHORIZE MY DOCTOR TO FURNISH AND DISCLOSE ALL FACTS CONCERNING THE TREATMENT.							
EMPLOYEE'S SIGNATURE _____    DATE _____							
<b>BRIEF OVERVIEW OF DENTAL BENEFITS</b>							
This chart is a brief summary of the Dental Benefits.							
Dental Benefit	90% of the usual, customary and reasonable cost associated with one oral cleaning per calendar year per covered individual, including costs associated with the office visit and one set of x-rays						
Dental Benefit Deductible	None						
<b>PROCEDURE FOR FILING A CLAIM</b>							
<b>INSTRUCTIONS TO THE EMPLOYEE:</b>							
1. Complete all applicable sections of Part 1-Employee Information and Part 2-Insurance Information. Failure to properly complete these sections may result in a delay in processing your claim.							
2. If you want the dental benefit payment sent directly to your dentist, sign on the bottom line of Part 3 (see reverse side of this form).							
3. Complete a separate form for each patient.							
4. Take this form to your dentist on your first visit. Upon completion of treatment complete and forward the form to the address below.							
<b>INSTRUCTIONS TO THE DENTIST:</b> The Trust accepts electronic submission of dental claims, send to: ChangeHealthcare F03 Payer ID 91136							
Or to submit a paper claim:							
1. Complete Part 3-Dentist Information, answer all questions and indicate all treatment performed.							
2. Indicate on the chart all missing teeth with an "X" and all abutments with an "O".							
3. Describe procedures for treatment of this case, give the date of service and the fee charged for each procedure. The use of the standard ADA codes will expedite the processing of this claim.							
4. For payment to be made directly to the dentist, the <b>employee must sign the bottom line on the reverse side of this form.</b>							
<b>Upon completion of treatment, return this form to:</b>							
<b>PIPE INDUSTRY HEALTH AND WELFARE FUND OF COLORADO</b> <b>P.O. BOX 34687</b> <b>SEATTLE, WASHINGTON 98124-1687</b> <b>PHONE: (800) 257-2168</b>							
<b>NOTE: If you have other Group Insurance as your primary coverage, you need to submit the itemized bill AND a copy of the matching insurance payment explanation.</b>							

**PART 3 – DENTIST INFORMATION**

DENTIST NAME		TELEPHONE NUMBER		IS PATIENT COVERED BY ANOTHER PLAN? IF "YES", NAME OF OTHER PLAN		YES	NO
DENTIST MAILING ADDRESS							
DENTIST CITY		STATE		ZIP			
NPI				IS ANY OF THE TREATMENT FOR ORTHODONTIC PURPOSES?			
YOUR TAX IDENTIFICATION NUMBER				TREATMENT RESULT OF ACCIDENT?			
OTHERWISE YOUR SOC. SEC. NO.				TREATMENT RESULT OF OCCUPATIONAL INJURY?			
(MUST BE FURNISHED UNDER AUTHORITY OF LAW)				ARE X-RAYS ENCLOSED? IF "YES", HOW MANY?			
IF PROSTHESIS, IS THIS INITIAL?	YES	NO	IF "NO", REASON FOR REPLACEMENT			DATE PRIOR PLACEMENT MO. DAY YEAR	
CHECK ONE  <input type="checkbox"/> DENTIST'S PRETREATMENT ESTIMATE  <input type="checkbox"/> DENTIST'S STATEMENT OF ACTUAL SERVICES				(WORK COMPLETED – PAYMENT REQUESTED) THE TREATMENT LISTED BELOW WAS COMPLETED AND WAS NECESSARY IN MY JUDGEMENT.  DENTIST SIGNATURE			

EXAMINATION AND TREATMENT RECORD																			
DATE FIRST VISIT (CURRENT SERIES) MO. DAY YEAR	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	NO. OF X-RAYS ETC.	ADA PROCEDURE NUMBER	DATE SERVICE PERFORMED		FEE	ADMIN. USE ONLY										
						MO.	DAY YEAR												
IDENTIFY MISSING TEETH WITH "X"																			

PATIENT NAME	IF PARTIAL/DENTURE – INDICATE START DATE: _____ DELIVERY: _____
	IF PROSTHESIS OR CROWN – INDICATE PREP DATE: _____ SEAT: _____
	IF ROOT CANAL – INDICATE START DATE: _____ FINISH: _____
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST OF THE GROUP DENTAL BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.	
<b>EMPLOYEE SIGNATURE</b> _____ <b>DATE:</b> _____	

**SEE OTHER SIDE FOR INSTRUCTIONS**  
**BENEFIT, CLAIMS PAYMENT AND ELIGIBILITY INFORMATION**  
**MAY BE OBTAINED FROM:**  
**WELFARE & PENSION ADMINISTRATION SERVICE, INC.**  
**PHONE: (206) 441-7574 or (800) 257-2168**