MARITIME ASSOCIATION - I.L.A. WELFARE FUND
11550 Fuqua, Suite 425
Houston, Texas 77034-4597
(281) 484-4343

Claim for Dental Expense Benefits

HOW TO FILE YOUR CLAIM:

1. Complete the Employee's Statement below.
2. Have your dentist complete the Attending Dentist Statement on the other side of this form.
3. ALL QUESTIONS MUST BE ANSWERED.

EMPLOYEE'S STATEMENT

Fully Complete For All Claims

Employee's Name (Please Print) | Birthdate (Mo.,Day,Year) | Social Security Number

Address: Street and Number | City, State and Zip Code

Date last worked in the ILA industry

Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced | Spouse's Social Security Number | Home Telephone Number | Local Number

If claim is for any child, is that child employed? ☐ Yes ☐ No

Is your spouse employed? ☐ Yes ☐ No If yes, give name of spoue and name and address of Employer.

Name of Spouse _____ Spouse's Birthdate _____

Name of Spouse's Employer | Address

Do you or your family have:

a) Other group insurance? ☐ Yes ☐ No
Give name of Employer and other insurance company _____

b) Give group number _____
Give certificate number _____

c) Government insurance? ☐ Yes ☐ No
What type? _____

d) Worker's Compensation? ☐ Yes ☐ No

* If these expenses are covered by other insurance and the other carrier is primary (that is, pays first), don't file this claim until you have received the payment from the other insurance. Submit the explanation of benefits from the other carrier with this claim.

Complete For All Injuries

Date of the injury? | Where did the injury occur? | How did the injury occur?

Is injury due to an automobile accident? ☐ Yes ☐ No

Employee or Dependent

Have you or will you file these bills for Worker's Compensation Benefits? ☐ Yes ☐ No

Are you presently receiving Worker's Compensation for any illness or injury? ☐ Yes ☐ No

If yes, please explain _____

Are you presently receiving any payment from an employer while disabled? ☐ Yes ☐ No

Complete Only For Dependent Claims

Name of Dependent | Birthdate | Relationship of Dependent | ☐ Married ☐ Single

If attending school give name of school

Sign Here

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. I hereby certify to the above statements.

I hereby authorize the release to and the use by Maritime Association-I.L.A. Welfare Fund of any medical or other information needed in processing this claim and certify the above information is correct.

Date _____ Employee Sign Here ⇒ _____

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/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

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

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