



# IBEW Local No. 236

## Health and Benefit Fund, Annuity Fund, and Pension Fund

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Funds Administrator

### GUIDELINES – DENTAL

Before submitting your application for **2-Party** reimbursement to the Health and Benefit Fund, please complete the appropriate section.

#### SECTION I.

##### **A. Dental Insurance Requirements:**

- Benefit claim for the item/service must be submitted to your Dental Insurance carrier before submitting for Health and Benefit reimbursement
- A denial letter from insurance carrier stating item is not allowed and reason(s) denied

##### **B. Signed Statement:**

- I certify that I have submitted all the required documents necessary to submit a claim to my Dental Insurance and I have no other carrier (s). Attached are all pertinent copies from my Dental Insurance provider (e.g. - my submission, denial(s), and EOB).

#### SECTION II.

       **I DO NOT HAVE DENTAL INSURANCE COVERAGE**

Name: (person who submitted claim – print clearly): \_\_\_\_\_

Date: \_\_\_\_\_

SS#: \_\_\_\_\_

Member Signature: \_\_\_\_\_

**Member/Provider agrees to refund IBEW Local 236 Funds Office any portion of money prepaid by Funds to Dental Provider/Member if Dental work is not completed or cancelled by member or dependent. Provider will notify Fund Office when all procedures are completed.**

Provider Signature: \_\_\_\_\_ (print name) \_\_\_\_\_

***It is a Federal Crime to file a false application for benefits. In addition, if you file a false application for benefits, you may forfeit your coverage under the plan.***

submission GUIDBLINES general



**GUIDELINES – PART I**

Before submitting your reimbursement to the Fund (e.g. large ticket items), the following must be completed:

**A. Health Insurance Carrier:**

- Benefit claim for the item/service must be submitted to your Health Insurance carrier before submitting for Health and Benefit reimbursement
- Explanation of benefits (EOB) from the carrier.

Where applicable:

- A denial letter from insurance carrier stating item is not allowed and reason(s) denied
- Properly documented appeal request of the denial submitted to insurance carrier
- Denial of appeal from insurance carrier stating reason (s) for denial

**B. Signed Statement:**

- I certify that I have submitted all the required documents necessary to submit a claim to my Health Insurance and I have no other carrier (s). Attached are all pertinent copies from my insurance provider (e.g. - my submission, appeal, denial(s), and EOB).

Name: (person who submitted claim – print clearly): \_\_\_\_\_

Date: \_\_\_\_\_

SS#: \_\_\_\_\_

Member Signature: \_\_\_\_\_