SOUTHERN PAINTERS
WELFARE PLAN
5 HOT METAL ST., SUITE 200
PITTSBURGH, PA 15203

TOLL-FREE: 1-844-851-7293
FAX: 1-412-431-4067

DENTAL/VISION CLAIM FORM

Member Name: _____
Social Security#: _____

Patient Name: _____
Patient Date of Birth: _____
Patient's Relationship to Insured: ↑Self ↑Spouse ↑Child

Services: Please have provider complete below and attach itemized bill of services.

Date of Service	Procedure Code	Explanation	Charges	Units
			Total Charges	Amount Paid

This form is for member reimbursement only.

If you prefer payment be issued directly to the provider of services, the provider should file the claim on your behalf. Vision claims are to be submitted on a HCFA 1500 and all dental claims should be submitted on the standardized ADA Dental Claim Form.

Si le interesa leer esta correspondencia en español por favor contacta la Oficina del Fondo.
Servicios para miembros en español a 1-844-851-7768