



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*