

RETURN THIS FORM TO:

Office and Professional Employees

Locals 30 & 537 Health & Welfare Trust Fund
13191 Crossroads Parkway North, Suite 205
City of Industry, CA 91714-3434
(562) 463-5065 • (800) 386-4350

NOTICE: IT IS ILLEGAL TO FILE A FALSE OR FRAUDULENT CLAIM OR TO KNOWINGLY HELP SOMEONE ELSE FILE ONE. YOU MAY BE FINED OR SENT TO PRISON FOR DOING SO. YOU MAY ALSO BE REQUIRED TO PAY CIVIL DAMAGES.



ATTENDING DENTIST'S STATEMENT

PATIENT INFORMATION
1. PATIENT NAME (FIRST, MI, LAST)
2. RELATIONSHIP TO INSURED (SELF, CHILD, SPOUSE, OTHER)
3. SEX (M, F)
4. PATIENT BIRTHDATE (MO, DAY, YEAR)
5. IF FULL TIME STUDENT (SCHOOL, CITY)
6. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS
7. EMPLOYEE/SUBSCRIBER SOC. SEC. OR I.D. NUMBER
8. EMPLOYEE/SUBSCRIBER BIRTHDATE (MO, DAY, YEAR)
9. EMPLOYER (COMPANY) NAME AND ADDRESS
10. GROUP NUMBER
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? (DENTAL, MEDICAL)
12-A. NAME AND ADDRESS OF CARRIER(S)
12-B. GROUP NO.(S)
13. NAME AND ADDRESS OF EMPLOYER
14-A. EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)
14-B. EMPLOYEE/SUBSCRIBER SOC. SEC. OR I.D. NUMBER
14-C. EMPLOYEE/SUBSCRIBER BIRTHDATE (MO, DAY, YEAR)
15. RELATIONSHIP TO PATIENT (SELF, PARENT, SPOUSE, OTHER)

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.
I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTAL ENTITY.
SIGNED (PATIENT, OR PARENT IF MINOR) DATE
SIGNED (INSURED PERSON) DATE

PRE-CERTIFICATION IS REQUIRED FOR CLAIMS IN EXCESS OF \$500.00. PLEASE SUBMIT X-RAYS.

BILLING DENTIST
16. NAME OF BILLING DENTIST OR DENTAL ENTITY
17. ADDRESS WHERE PAYMENT SHOULD BE REMITTED (CITY, STATE, ZIP)
18. DENTIST SOC. SEC. OR T.I.N. 19. DENTIST LICENSE NO. 20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT (OFFICE, HOSP, ECF, OTHER)
23. RADIOGRAPHS MODELS ENCLOSED? (NO, YES) HOW MANY
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? (NO, YES) IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT?
26. OTHER ACCIDENT
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? (IF NO, REASON FOR REPLACEMENT)
29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS? (IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED, MOS TREATMENT REMAINING)

IDENTIFY MISSING TEETH WITH "X"
31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.
TOOTH # OR LETTER SURFACE DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) DATE SERVICES PERFORMED (MO, DAY, YEAR) PROCEDURE NUMBER FEE FOR ADMINISTRATIVE USE ONLY
REMARKS FOR UNUSUAL SERVICES

MUST BE COMPLETED IN ALL CASES AFTER WORK HAS BEEN DONE
I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED AND TO THE BEST OF MY KNOWLEDGE ARE WITHIN THE PROVISIONS OF THE GROUP DENTAL PLAN. PAYMENT IS THEREFORE DUE.
TOTAL FEE CHARGED
PATIENT'S SIGNATURE (or parent if patient is a minor) Date DENTIST'S SIGNATURE Date

For Administrative Office Use Only: CERTIFICATION FOR DENTAL BENEFITS
Date
The benefits described below are effective July 1, 1996.
Listed allowance is payable at 100% for preventive and diagnostic procedures, and 90% for all other procedures after \$50.00 deductible per calendar year. Payment of benefits is subject to the following: (1) Patient must be eligible at the time of service, (2) Maximum benefit per calendar year is \$1,250.00, and (3) Benefits are subject to coordination of benefits, prior benefits paid and Plan provisions. When service is completed, indicate date of service on this claim form and submit for payment.
Listed allowance is payable at 90%. The maximum lifetime orthodontic benefit is \$1,250.00. Please submit claim when banding is completed, with date and amount charged or banding date. Quarterly claims thereafter. Benefits are subject to coordination of benefits, prior benefits and patient must be eligible at the time of service.
This claim cannot be pre-authorized as the patient is not eligible for benefits at this time.
Please note that certain procedures have been excluded or replaced with alternative procedures that meet the policy provisions of necessary, reasonable and customary.
For eligibility or any questions, please contact the claims office.