RV 08-05

UFCW Local 1459 and Contributing Employers Health & Welfare Fund

33 Eastland Street
Springfield, MA 01109
(413) 733-0177 or Toll Free 1-800-634-2700

DENTAL CLAIM FORM

INSTRUCTIONS FOR MAKING A CLAIM FOR BENEFITS:

1. **Answer all required questions on this side of form, and sign it at the bottom.**
2. **If you want us to pay the hospital or doctor directly, sign the "Assignment of Benefits" section on the reverse side.**
3. **Have your doctor complete the Attending Dentist's Statement or attach an itemized bill indicating the patient's name, diagnosis, place and date of each service, and the amount charged.**

EMPLOYEE INFORMATION

Employee Name (First, Middle, Last)	Plan No. K119	Social Security Number
Home Address City State Zip	Date of Birth	Daytime Phone Number
	Marital Status ? Single ? Divorced ? Married ? Widowed	Work Status ? Active ? Disabled ? Retired ? Other (specify)

PATIENT INFORMATION

Patient Name (First, Middle, Last)	Date of Birth
Relationship to Employee ? Self ? Spouse ? Child* ? Other(specify)	Sex ? Male ? Female

*Is Child Married? ? Yes ? No Full-time student? ? Yes ? No

Are natural parents divorced or separated? ? Yes ? No

Does natural parent WITHOUT custody have financial responsibility for health expenses? ? Yes ? No

SPOUSE INFORMATION

Spouse's Name (First, Middle, Last)	Spouse's Date of Birth
Spouse's Social Security Number	Employment Status ? Active ? Retired ? Not Employed
Spouse's Employer Name and Address	

Describe sickness or injury. If injury, where and how did it occur?

Date sickness began or injury occurred	Did injury occur at work? ? Yes ? No Was sickness caused by work? ? Yes ? No	Was injury caused by an automobile accident? ? Yes ? No If yes, specify city and state

OTHER INSURANCE DATA (Complete the following section if you or any member of your family is covered by any other health plan or Medicare)

Name of Person Covered by Other Insurance (First, Middle, Last)			Name and Address of Insurance Company
Relationship to You of Person Covered by Other Insurance ? Self ? Patient ? Spouse ? Other: specify relationship			
Policy or Plan No.	Ins. ID Number	Type of Coverage ? Individual ? Medical ? Family ? Dental	

AUTHORIZATION FOR RELEASE OF INFORMATION

I/We authorize the release to the UFCW Local 1459 and Contributing Employers Health & Welfare Fund and its agents of any evidence or information about me or my dependents that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original.

______________________________ __________________ ____

Employee's Signature Date Patient's Signature (if patient is legal adult) Date

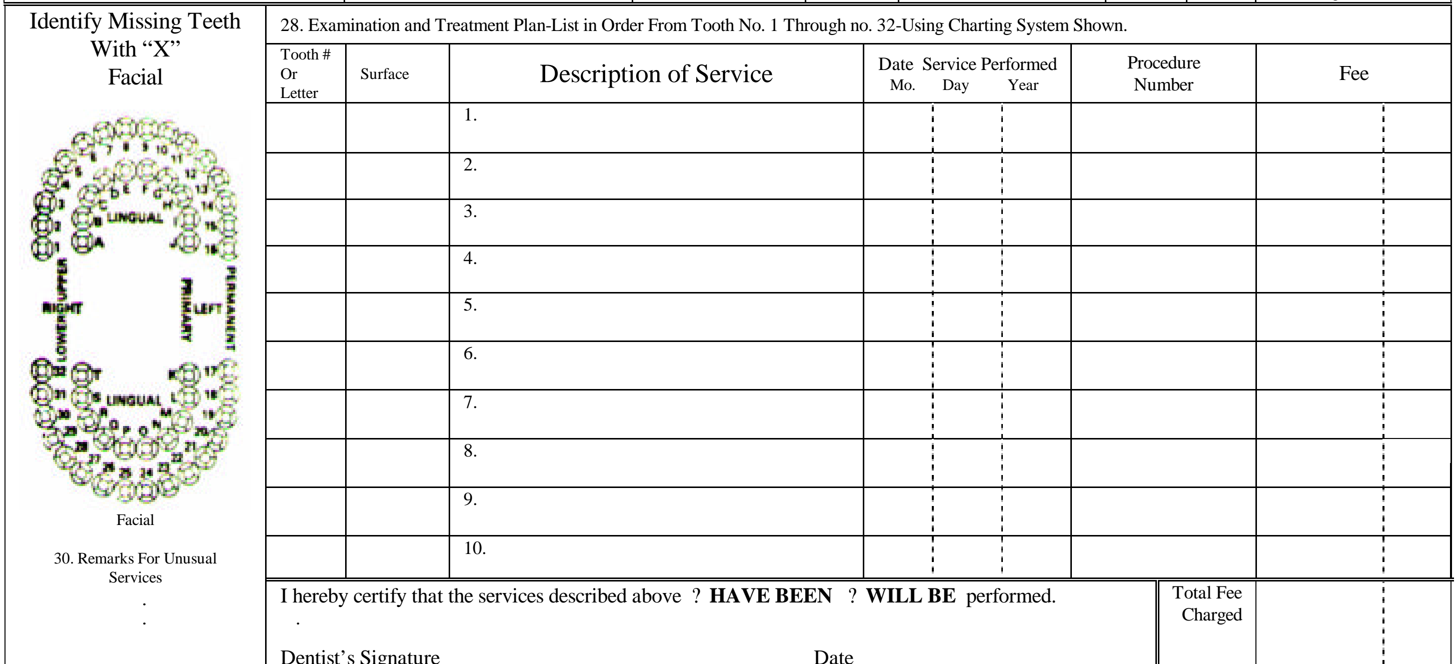
ATTENDING DENTIST'S STATEMENT

TYPE OR PRINT (ITEMS 4 - 8 AND 11 BELOW NEED NOT BE FILLED IN IF EMPLOYEE'S STATEMENT ON OTHER SIDE IS COMPLETED)

1. Patient's Name (First, Middle, Last)	2. Patient's Date of Birth	3. Employee's Name (First, Middle, Last)
4. Patient's Address (Street, city, state, ZIP code) Telephone No.	5. Patient's Sex ? Male ? Female 7. Patient's Relationship to Employee ? Self ? Spouse ? Child ? Other	6. Employee's Social Security No.
9. Other Dental Coverage – Enter Name of Policyholder, Plan Name and Address, and I.D. Number	10. Was Condition Related to A. Patient's Employment ? Yes ? No B. An Auto Accident ? Yes ? No	11. Employee's Address (Street, city, state, ZIP)

ASSIGNMENT OF BENEFITS	12. I Authorize Payment of benefits to the undersigned dentist or supplier for the services described below. Employee's Signature

		No	Yes	
13. Dentist Name	21. Is Treatment Result of Occupational Illness or Injury?			If Yes, Enter Brief Description & Dates
14. Mailing Address	22. Is Treatment Result of Auto Accident?			
	23. Other Accident?			
CITY, STATE, ZIP	24. Are Any Services Covered By Another Plan?			
15. Dentist Tax ID or Soc. Sec. 16. Dentist License No. 17. Dentist Phone No.	25. If Prosthesis, is This Initial Placement?			If No, Reason for Replacement 27. Date of Prior placement?
18. First Visit Date of Current Series? 19. Place of Treatment ? Office ? Hosp. ? ECF ? Other 20. Radiographs or Models Enclosed? ? Yes ? No How Many?	26. Is Treatment For Orthodontics?			If Services Already Commenced, Enter: Date Appliance Placed Mos. Treatment Remaining



Identify Missing Teeth With "X"
Facial

Facial

30. Remarks For Unusual Services

28. Examination and Treatment Plan-List in Order From Tooth No. 1 Through no. 32-Using Charting System Shown.

Tooth # Or Letter	Surface	Description of Service	Date Service Performed Mo. Day Year	Procedure Number	Fee
		1.			
		2.			
		3.			
		4.			
		5.			
		6.			
		7.			
		8.			
		9.			
		10.			

I hereby certify that the services described above ? **HAVE BEEN** ? **WILL BE** performed.

Dentist's Signature Date

Total Fee Charged

DO NOT SEND X-RAYS