PRINT OR TYPE YOU ARE PREPARING MULTIPLE COPIES

READ INSTRUCTIONS ON BACK BEFORE COMPLETING FORM

DENTIST: RETAIN LAST COPY FOR YOUR FILES, FORWARD ALL OTHER COPIES.

CLAIMS MUST BE FILED WITHIN 90 DAYS FROM DATE OF TREATMENT

RETURN FORM TO: CONTRACTORS, LABORERS, TEAMSTERS AND ENGINEERS
HEALTH AND WELFARE PLAN
10334 ELLISON CIRCLE
OMAHA, NEBRASKA 68134
1-402-491-3751

STATEMENT OF DENTAL CLAIM

PART 1

NAME OF EMPLOYEE | SOCIAL SECURITY NO. | AGE | Employee's Marital Status: M. / S. / Wid. / Div. / Legal Sep. | ☐ Male ☐ Female

STREET ADDRESS | OCCUPATION | EMPLOYED BY | DATE EMPLOYED

CITY STATE ZIP | IS PATIENT COVERED BY ANOTHER PLAN? ☐ YES ☐ NO IF YES, PLEASE IDENTIFY

NAME OF PATIENT | RELATIONSHIP TO EMPLOYEE | BIRTHDATE OF PATIENT MO. DAY YEAR | Patient's Marital Status: M. / S. / Wid. / Div. / Legal Sep. | ☐ Male ☐ Female | DATE OF PATIENT'S FIRST VISIT (CURRENT SERIES)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN BELOW. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

SIGNED (EMPLOYEE) ______________ DATE ______

I HEREBY ACCEPT THE FOLLOWING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT OR PARENT IF MINOR)

PART 2

DENTIST NAME | LICENSE NUMBER

DENTIST MAILING ADDRESS | PHONE NUMBER

CITY STATE ZIP

IF PROSTHESIS, IS THIS INITIAL YES | NO (IF NO, REASON FOR REPLACEMENT) | DATE OF PRIOR PLACEMENT

	YES	NO
IS PATIENT COVERED BY ANOTHER PLAN? IF YES, ENTER NAME AND ADDRESS OF OTHER PLAN:		
IS ANY OF TREATMENT FOR ORTHODONTIC PURPOSES?		
TREATMENT RESULT OF ACCIDENT?		
RESULT OF OCCUPATIONAL INJURY?		

ADMINISTRATIVE USE ONLY

CRAFT

EFF. DATE OF INS.

TERM DATE (IF ANY)

BY

CHECK ONE: ☐ DENTIST'S PRETREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

PART 3

DOCTOR: PLEASE COMPLETE ONLY THE NON-SHADED INFORMATION IN PARTS 2 AND 3.

EXAMINATION AND TREATMENT RECORD LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	PROCEDURE NUMBER*	DATE SERVICE PERFORMED MO	DAY	YEAR	FEE	FOR FUND OFFICE USE ONLY
			TOTALS					

*Dentist: Please use code printed in JADA Vol. 92, March 1976

PATIENT NAME

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST)

INDIVIDUAL PRACTITIONERS SS #

ALL OTHERS - EMPLOYEE I.D. #

MUST BE FURNISHED UNDER AUTHORITY OF LAW

COORDINATION OF BENEFITS

	TYPE	AMT. CHARGE	-	AMOUNT C.O.B.	=	BALANCE DUE

DRAFT NO. ______

ISSUED TO ______

DEDUCTIBLE (If Any)	
COINSURANCE (Payable At) %	
TOTAL PAYMENT THIS AUDIT	

® 2 ©

PART 1 INSTRUCTIONS FOR THE EMPLOYEE

1. Complete Part 1 of this form by answering all questions. (Please Print.)
2. Sign Part 1 of the form where indicated.
3. Take the form to your provider. The form will be completed by your Provider and sent to the Fund Office.

PARTS 2 AND 3 INSTRUCTIONS FOR THE PROVIDER

1. Complete Part 2 of this form by answering all questions. (Please Print.)
2. Upon completion of treatment, sign the original of the form (at bottom).
3. After the form is completed by your office, send the itemized form to the Fund Office for processing.

RETAIN THE LAST COPY AND SEND THE REMAINING COPIES TO THE ADDRESS SHOWN ON THE FRONT OF THE FORM AT THE TOP. IF THE PATIENT IS ELIGIBLE, BENEFITS WILL BE PAID ACCORDING TO THE PLAN'S SCHEDULE OF ALLOWANCES AND LIMITATIONS.

FAILURE TO COMPLETE THIS FORM, MAY CAUSE A DELAY IN PROCESSING THE CLAIM.

FOR ADDITIONAL INFORMATION OR ASSISTANCE, PLEASE CALL 402-491-3751.