United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund
18861 90th Ave, Suite A, Mokena IL 60448
800-621-5133 * Fax 847-384-0197 * www.ufcwmidwest.org

Dental Claim Form

Instructions for Employee-Member

You complete the front of the form; your dentist completes the reverse; return the completed form to the above address. You may use this form or substitute a similar form from your dentist.

Pre-Treatment Estimate - Before you begin dental treatment, you may request an estimate of the benefits payable for the benefits payable for the proposed treatment. You and your dentist complete this form, mark the box "Pre-Treatment Estimate" and return to the above address. The Benefits Fund Office will determine benefits and will forward the estimate to your dentist and to you.

Employee-Member and Claim Information - Receipt of this claim form does not guarantee payment of benefits

1. YOUR FULL NAME (EMPLOYEE-MEMBER)	MAIDEN NAME	UFCW ID# OR SOCIAL SECURITY NUMBER

2. STREET ADDRESS	CITY	STATE	ZIP	CHECK IF NEW ADDRESS ☐

3. DAYTIME PHONE NUMBER	☐ MALE ☐ FEMALE	DATE OF BIRTH	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED	DATE MARRIED

4. NAME AND ADDRESS OF ANY NON-UFCW COMPANY WHERE YOU ARE ALSO EMPLOYED

5. IS ANY PART OF TREATMENT DUE TO AN ACCIDENT?	IS ANY PART OF TREATMENT DUE TO PATIENT'S OCCUPATION?
☐ YES ☐ NO	☐ YES ☐ NO

Spouse Information - Complete for all Claims

6. FULL NAME OF SPOUSE	DATE OF BIRTH	SOCIAL SECURITY NUMBER

7. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS	CITY	STATE	ZIP	DAYTIME PHONE NUMBER

8. NAME AND ADDRESS OF SPOUSE'S EMPLOYER (OR FORMER EMPLOYER)	PHONE NUMBER

Dependent Child Information - Complete Only if Claim is for a Dependent Child

9. DEPENDENT'S FULL NAME - FIRST AND LAST NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

10. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS	CITY	STATE	ZIP	DAYTIME PHONE NUMBER

11. EMPLOYER NAME AND ADDRESS	CHECK IF NOT EMPLOYED ☐

Other Insurance Information - Complete for all Claims

12. IS PATIENT COVERED UNDER ANY OTHER GROUP HEALTH INSURANCE OR BENEFIT PLAN, SUCH AS, GROUP BLUE CROSS A SCHOOL PLAN, A GOVERNMENT PLAN, AN AUTO INSURANCE PLAN, ETC.? IF "YES," PLEASE PROVIDE THE INFORMATION REQUESTED BELOW. ☐ YES ☐ NO

13. POLICYHOLDER'S FULL NAME - FIRST AND LAST NAME	RELATIONSHIP TO EMPLOYEE-MEMBER	DAYTIME PHONE NUMBER

14. NAME OF PLAN OR COMPANY	POLICY NUMBER

15. ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

Signatures - Employee-Member and Patient (or Parent, if patient is a minor) must sign or benefits cannot be paid

I certify that the above answers and statements, including any accompanying statements, are true and complete to the best of my knowledge and belief. I authorize any dentist, physician, medical examiner or or practitioner, coroner, hospital, Veterans Administration Hospital, clinic, other medical-related facility, insurance or reinsuring company, consumer reporting agency, employer, school, or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the patient for whom claim is made, to give to UFCW Calumet Region Insurance Fund or its legal representative, any and all such information. A photocopy of this authorization shall be valid as the original.

Date _____ Signature _____ ☜ Employee-Member sign here

Date _____ Signature _____ ☜ Patient (or Parent) sign here

Assignment of Benefits: Authorization to Pay Benefits to Dentist - Sign only if benefits to be paid directly to provider

I hereby authorize payment directly to the dentist for any Dental Benefits otherwise payable to me for services in connection with this claim.

Date _____ Employee-Member Signature _____

(Your Dentist should complete the reverse side)

Attending Dentist's Statement

Use this form or attach a similar form of your own

Do not send radiographs or models unless specifically requested by the Benefits Office

EMPLOYEE-MEMBER NAME	UFCW ID# OR SOCIAL SECURITY NUMBER	PATIENT NAME

DENTIST NAME	DEGREE	DENTIST LICENSE NUMBER

15. MAILING ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

TAX ID# OR SOCIAL SECURITY NUMBER (MUST BE FURNISHED UNDER AUTHORITY OF LAW)

FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT	RADIOGRAPHS OR MODELS ENCLOSED?
	☐ OFFICE ☐ HOSP ☐ ECF ☐ OTHER	☐ NO ☐ YES HOW MANY? _____

CHECK ONE: □ DENTIST'S PRE-TREATMENT SERVICE □ DENTIST'S STATEMENT OF ACTUAL SERVICES

IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?

☐ NO ☐ YES IF YES, ENTER BRIEF DESCRIPTION AND DATES _____

IS TREATMENT RESULT OF AUTO ACCIDENT?

☐ NO ☐ YES IF YES, ENTER BRIEF DESCRIPTION AND DATES _____

IS TREATMENT RESULT OF OTHER ACCIDENT?

☐ NO ☐ YES IF YES, ENTER BRIEF DESCRIPTION AND DATES _____

ARE ANY SERVICES COVERED BY ANOTHER PLAN? ☐ NO ☐ YES

IF YES, PLEASE PROVIDE ALL INFORMATION: _____

IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ☐ NO ☐ YES DATE OF PRIOR PLACEMENT _____

IF NO, REASON FOR REPLACEMENT _____

IS TREATMENT FOR ORTHODONTICS? ☐ NO ☐ YES

IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED: _____ MONTHS TREATMENT REMAINING: _____

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

(FACIAL/ UPPER/RIGHT TO LEFT: USE NUMBERS 1 - 16 FACIAL/LOWER/LEFT TO RIGHT: USE NUMBERS 17 - 32)

(LINGUAL/UPPER RIGHT TO LEFT: USE LETTERS A - J LINGUAL/LOWER/LEFT TO RIGHT: USE LETTERS K - T)

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC)	DATE SERVICE PERFORMED	ADA PROCEDURE NO	FEE	FOR ADMIN. USE ONLY
				TOTAL FEE		
				AMOUNT PAID		
				BALANCE DUE		

I hereby certify that the procedures as indicated by date have been completed

Date _____ Signature of Dentist _____