W-2
1/96

CONSTRUCTION INDUSTRY LABORERS WELFARE FUND

116 COMMERCE DRIVE • JEFFERSON CITY, MISSOURI 65109 • (573) 893-2446

DENTAL BENEFITS CLAIM

CHECK ONE:
☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

EMPLOYEE **MUST** COMPLETE TOP SECTION EVEN IF DENTIST USES OWN CLAIM FORM.

EMPLOYEE SECTION

PATIENT NAME

Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other | Sex ☐ M ☐ F | Patient Birthdate Mo. - Day - Year | Full time student? ☐ Yes ☐ No

EMPLOYEE/NAME First Middle Last

EMPLOYEE MAILING ADDRESS NEW ADDRESS ? ☐ YES

CITY, STATE, ZIP

EMPLOYEE'S SOCIAL SECURITY NUMBER **MUST** BE PROVIDED

☐☐☐-☐☐-☐☐☐☐

IS ANY DEPENDENT UNDER THIS PLAN EMPLOYED? ☐ YES ☐ NO

DO YOU OR YOUR COVERED DEPENDENTS HAVE OTHER GROUP HEALTH COVERAGE? ☐ YES ☐ NO IF YES, PLEASE IDENTIFY: ☐ SPOUSE ☐ EMPLOYEE ☐ CHILD.

NAME_____ DATE OF BIRTH _____

SOC. SEC. NO. OF PERSON WITH OTHER COVERAGE

☐☐☐-☐☐-☐☐☐☐

POLICY NO./ I.D. NO. _____

EFF. DATE _____

OTHER HEALTH COVERAGE

NAME _____

ADDRESS _____

DOES OTHER GROUP COVERAGE LISTED ABOVE HAVE DENTAL BENEFITS ☐ YES ☐ NO

I authorize release of any information related to this claim. If the claim is for a dependent, the dependent meets the eligibility requirements as outlined in the Summary Plan Description.

MUST BE SIGNED

Signed (patient, or parent if minor) Date

I hereby authorize payment directly to the below named dentist of the group benefits otherwise payable to me.

ASSIGNMENT

Signed (employee) Date

ATTENDING DENTIST'S STATEMENT

X-RAYS OR STUDY MODELS TO BE SUBMITTED **UPON REQUEST ONLY**

1. DENTIST'S NAME

2. MAILING ADDRESS NEW ADDRESS? ☐ YES

STREET

CITY STATE ZIP

3. Enter the **TAXPAYER IDENTIFYING NUMBER** to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.

4. DENTIST PHONE NO.

5. FIRST VISIT DATE CURRENT SERVICE

6. Is treatment result of occupational injury? [ ] Yes [ ] No Auto accident? [ ] Yes [ ] No

If accident, enter brief description and dates.

7. Other accident? [ ] Yes [ ] No

8. Are any services covered by another plan? [ ] Yes [ ] No

9. If yes, plan name?

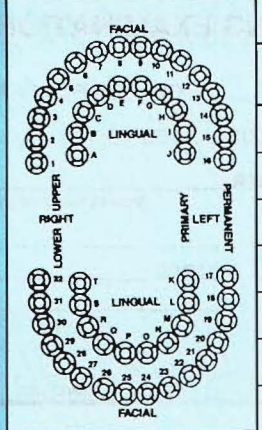
10A. If no, reason for replacement and Date of prior placement

10. If prosthesis is this initial placement? [ ] Yes [ ] No

11. Is treatment for orthodontics? [ ] Yes [ ] No

If services already commenced, enter dates appliances placed, months treatment remaining.

ADMINISTRATIVE USE ONLY



12. 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 Service Performed Mo. Day Year	Procedure Number	Fee
		1			
		2			
		3			
		4			
		5			
		6			
		7			
		8			
		9			
		10			
		11			
		12			
		13			

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE FEES I USUALLY CHARGE AND ACCEPT FOR SUCH PROCEDURES.

TOTAL FEE CHARGED

SIGNED (DENTIST) *DATE*