UFCW LOCAL ONE HEALTH CARE FUND

5911 Airport Road

Oriskany, NY 13424

(Please Read Instructions on Reverse Side before Completing this form)

Dental Expense Claim Form

TO BE COMPLETED BY PATIENT

1. Patient First Name | Middle | Last
2. Relationship to Employee: Self | Spouse | Child | Other
3. Sex: M | F
4. Married: Yes | No
5. Patient Date of Birth: Mo | Day | Year
6. If Full Time Student (Age 19 or Over) School | City | State
7. EMPLOYEE SOC. SEC. NO.
8. If Disabled (Age 19 or Over) ☐ Yes ☐ No
9. Name of Group Dental Program: UFCW Local One Health Care Fund
10. Employee First Name | Middle | Last
11. Employee Date of Birth
12. Office Phone (area code)
13. Employee Residence Mailing Address
14. City, State, Zip
15. Are other Family Members Employed? ☐ Yes ☐ No Name | Soc. Sec. No.
16. Date of Birth
17. Name and Address of Employer for Item 15
18. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, Complete the Following) Dental Plan Name | Group No. | Name and Address of Carrier
19. I Authorise Release of any Information Relating to this Claim.

Signed (Patient, or Parent if Minor) ____________ Date ________

20. I Certify that the Above Information is Correct. I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT. FAILURE TO PROVIDE CORRECT INFORMATION MAY RESULT IN YOUR BEING RESPONSIBLE FOR ALL CHARGES.

Employee Signature ____________ Date ________

TO BE COMPLETED BY DENTIST

21. Dentist Name
22. Mailing Address | City, State Zip
23. Dentist N PI#
24. Dentist Soc. Sec. No. or T.I.N.
25. Dentist Phone No.
26. First Visit Date Current Series
27. Place of Treatment: Office | Hosp | ECF | Other
28. Radiographs Models Enclosed? No | Yes | How Many?

	No	Yes	If Yes, Enter Breif Description and Dates
29. Is Treatment Result of Occupational Illness or Injury?			
30. Is Treatment Result of Auto Accident?			
31. Other Accident?			
32. Are any Services Covered by Another Plan?			
33. If Prosthesis, is this Initial Placement?			(If No, Reason For Replacement) / 34. Date of Prior Placement
35. Is Treatment for Orthodontics?			Is Services Already Commenced, Enter / Date Appliance Placed / Mos. Treatment Remaining

Dentist's

☐ Pre-Treatment Estimate

☐ Statement of Actual Service

*(Be Sure To Sign Below)

36. 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 Services (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line No.	Date Service Performed Mo.	Day	Yr.	ADA Procedure Number	Fee	For Carrier Use Only

FACIAL — UPPER — 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 — A B C D E F G H I J — LUNGUAL — RIGHT — PRIMARY — LEFT — PERMANENT — LOWER — 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 — T S R Q P O N M L K — LINGUAL — FACIAL

Indicate Missing Teeth With an "X"

I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed
I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT. FAILURE TO PROVIDE CORRECT INFORMATION MAY RESULT IN NON-PAYMENT OF BENEFITS.

Total Fee Actually Charged ________

*Signed (Dentist) ____________ Date ________

Please review Before Submitting Claim

Information for Employee

1. Complete your section of the claim form (items 1 through 20) in full to assure positive identification and prompt payment. Please print or type. Note that item 7 (employee social security number) **must be completed** for the claim to be processed.

2. The patient (or parent if patient is a minor) MUST SIGN ITEM 1 9. (We do not accept "signature of file".)

3. You must sign the claim form in item 20. (We do not accept "signature on file".)

4. If total charges for the planned course of treatment are expected to be $250 or more the form should be completed and submitted to UFCW LOCAL ONE HEALTH CARE FUND **prior to the commencement of the course of treatment** for a pretreatment estimate of benefits. UFCW LOCAL ONE HEALTH CARE FUND will notify you of your benefits payable. (If you wish, a pretreatment estimate may be requested for anticipated dental expenses of less than $250.)

5. If total charges for the planned course of treatment will be less than $250, the claim form should be completed when treatment is completed and mailed to the address below.

Dental coverage is subject to specific limitations and exclusions. Please refer to your booklet for a description of covered services, schedule of benefits payable, limitations and exclusions.

Information for Attending Dentist

1. Benefits are payable in accordance with four Classes of Services. It is therefore important that a separate fee is indicated for each item of service performed.

2. If total charges for a completed course of treatment are less than $250, check the box noted "Statement of Actual Services" and complete item 23 through 38. The claim form should be sent to the address shown below.

3. If total charges for a course of treatment are expected to be $250 or more check box noted "Pre-Treatment Estimate" and complete items 23 through 38. The completed claim form should be sent to UFCW LOCAL ON HEALTH CARE FUND **prior to the commencement of the course of treatment.** UFCW LOCAL ONE HEALTH CARE FUND will review the claim (and any supplementary information required) and notify your patient of the benefits payable.

   A pretreatment estimate of benefits is not intended to preclude a course of treatment agreed upon by you and your patient. The intent is to avoid any misunderstanding concerning the benefits payable under the dental plan. A pretreatment estimate is not necessary for oral examinations, cleaning, fluoride applications, dental x-rays, or emergency treatment.

4. **SCHEDULE FOR SUBMISSION OF CLAIM FORMS**
   In the event the work proposed by your dentist extends beyond **90 days** from the date of your visit, your dentist must submit a claim form to the Fund Office at the end of the **90-day** period for work completed. He must submit an additional claim form to cover work done following the **90-day** period.

5. Generally, we do not request x-rays where standard filling materials are used. Pre-operative x-rays are requested only in connection with prosthetics, fixed bridgework, or cast restorations. Occasionally we may request x-rays that relate to other dental services.

Mail completed form to: **UFCW LOCAL ONE HEALTH CARE FUND**
5911 Airport Road
Oriskany, NY 13424
ATT: Dental Department

Claim Inquiries: **1-800-959-9497**