Dental Benefits Program

UFCW Local 1776
and Participating Employers
Health and Welfare Fund
3031B Walton Road
Plymouth Meeting, PA 19462
(610) 941-9400

CLAIM NUMBER

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

MEMBER COMPLETES

1. PATIENT NAME
2. RELATIONSHIP TO PARTICIPANT — SELF 1☐ SPOUSE 2☐ DAUGHTER 3☐ SON 4☐ OTHER 5☐
3. SEX — ☐ MALE ☐ FEMALE
4. PATIENT'S BIRTH DATE — MO. | DAY | YEAR
5. IF FULL TIME STUDENT — SCHOOL — CITY
6. PARTICIPANT NAME — FIRST MIDDLE LAST
7. PARTICIPANT SOCIAL SECURITY NUMBER
8. PARTICIPANT MAILING ADDRESS — CITY — STATE — ZIP CODE
9. NAME OF EMPLOYER
10. PATIENT MAILING ADDRESS
11. DO OTHER FAMILY MEMBERS HAVE DENTAL COVERAGE? — EMPLOYEE NAME — SOC. SEC. NO. — YES☐ NO☐
12. NAME AND ADDRESS OF EMPLOYER (IN ITEM 11)
13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? — YES☐ NO☐ — IF YES, GIVE PLAN NAME — UNION LOCAL — GROUP NO. — SPOUSE BIRTH DATE MO. | DAY — NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF AND INFORMATION RELATING TO THIS CLAIM.

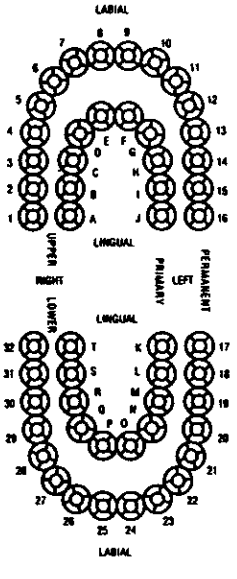
X
SIGNED (PATIENT, OR PARENT IF MINOR) — DATE SIGNED

DENTIST COMPLETES

14. DENTIST'S NAME
15. MAILING ADDRESS — CITY — STATE — ZIP CODE
16. DENTIST'S SOC. SEC. NO. (OR T.I.N.)
17. DENTIST'S LIC. NO.
18. DENTIST'S PHONE NO.
19. FIRST VISIT DATE CURRENT SERIES
20. PLACE OF TREATMENT — OFFICE | HOSP. | ECF | OTHER
21. RADIOGRAPHS OR MODELS ENCLOSED — NO | YES | HOW MANY?

	NO	YES	
22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
23. IS TREATMENT RESULT OF AUTO INJURY?			
24. OTHER ACCIDENT?			
25. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			IF THE PROGRAM IS SECONDARY, ATTACH COPY OF PRIMARY CARRIER'S PAYME
26. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR PLACEMENT — 27. DATE OF PRIO PLACEMENT
28. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: — DATE APPLIANCES PLACED — NO. OF TREATMEN REMAINING

DENOTE MISSING TEETH WITH "X"



29. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32. SEE CHARTING SYSTEM SHOWN.

	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED,ETC.	DATE SERVICE PERFORMED MO. DAY YR.	PROCEDURE NUMBER	FEE	FOR OFFICE USE ONLY: NO. OF TIMES PERFORMED	ELIG. ACT.	REPR COD
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2									
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30. REMARKS FOR UNUSUAL SERVICES

IF MORE LINES ARE NEEDED, PLEASE USE AN ADDITIONAL REPORT FORM (S) COMPLETING BOXES 1, 6, 8, AND 10 AT THE TOP OF THE FORM AND CHECK HERE →

TOTAL FEE CHARGED — NO. OF LINES

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

X
SIGNED (DENTIST) — DATE SIGNED

MY FEE ☐ HAS BEEN PAID ☐ HAS NOT BEEN PAID

FOR OFFICE USE ONLY

PAYEE CODE 1 2 3 4 5	CORRESPONDENCE CODE	PARTIC. STATUS 2 3 4 6	COB	ELIG. BYP.	X-RAY	DDS BYP.	EXAM.	REMARKS
		GROUP NO.		AUTHORIZED SIGNATURE			ELIGIBILITY DATE	