

**EMPLOYEE CLAIM FORM AND  
ATTENDING DENTIST'S STATEMENT  
EMPLOYEE SECTION**

**LOCAL UNION 831  
EMPLOYER HEALTH & WELFARE  
TRUST FUND**

Mail to: LOCAL UNION 831  
P.O. Box 5528  
El Monte, CA 91734  
(626) 279-3080

NAME AND ADDRESS OF EMPLOYER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

EMPLOYEE'S NAME (Last, First, Middle Initial) \_\_\_\_\_ EMPLOYEE'S ADDRESS (No., Street, City, State, Zip Code) Is this a new address?  YES  NO

EMPLOYEE'S DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ CLAIM IS FOR  
 EMPLOYEE  SPOUSE  CHILD  OTHER (Specify) \_\_\_\_\_

PATIENT'S GENDER  MALE  FEMALE PATIENT'S DATE OF BIRTH \_\_\_\_\_ PATIENT'S NAME IF NOT EMPLOYEE \_\_\_\_\_

IF CHILD 19 OR OVER INDICATE \_\_\_\_\_ IF STUDENT INDICATE NAME AND ADDRESS OF SCHOOL \_\_\_\_\_  
 HANDICAPPED  STUDENT

ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN?  YES  NO IF YES, COMPLETE THE FOLLOWING:

NAME OF EMPLOYED FAMILY MEMBER \_\_\_\_\_

NAME AND ADDRESS OF HIS OR HER EMPLOYER \_\_\_\_\_

NAME AND ADDRESS OF HIS OR HER EMPLOYER'S INSURANCE CARRIER \_\_\_\_\_

IDENTIFICATION NUMBER OR POLICY NUMBER \_\_\_\_\_ IF BLUE SHIELD GIVE CERTIFICATE NO. \_\_\_\_\_ SUBSCRIBER NO. \_\_\_\_\_

I HEREBY AUTHORIZE RELEASE OF X-RAYS AND ANY OTHER INFORMATION RELATING TO THIS CLAIM. I declare and certify that the foregoing statements made by me are true, to the best of my knowledge and belief. I am aware that if any of the statements made by me are willfully false, I may be subject to criminal and civil penalties.

SIGNED \_\_\_\_\_ (Patient or Parent if Patient is a minor)

I HEREBY AUTHORIZE PAYMENT OF THE GROUP DENTAL BENEFITS OTHERWISE PAYABLE TO ME, DIRECTLY TO THE DENTIST NAMED BELOW.

SIGNED \_\_\_\_\_ (Patient or Parent if Patient is a minor)

**DENTIST SECTION** BEFORE COMPLETING READ INSTRUCTIONS ON LAST PAGE FOR CLAIM SUBMITTAL & NECESSARY NOMENCLATURE & PROCEDURE CODES

DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES ENTER BRIEF DESCRIPTION AND DATES					
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?								
CITY STATE ZIP	ARE ANY SERVICES COVERED BY ANOTHER PLAN?								
DENTIST SOC SEC OR TIN	DENTIST LICENSE NO.	DENTIST PHONE NO.	IF PROSTHESIS IS THIS INITIAL PLACEMENT?	IF NO REASON FOR REPLACEMENT DATE OF PRIOR PLACEMENT					
FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFFICE HOSP ECF OTHER	RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY?	IS TREATMENT FOR ORTHODONTICS?	IF SERVICES ALREADY COMMENCED ENTER	DATE APPLIANCES PLACED	MOS TREATMENT REMAINING

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

IDENTIFY MISSING TEETH WITH X	EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN						FOR ADMINISTRATION USE ONLY	
	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO DAY YEAR	ADA PROCEDURE NUMBER	FEE	<input type="checkbox"/> SCHEDULE	<input type="checkbox"/> U&C
			1				%	%
			2					
			3					
			4					
			5					
			6					
			7					
			8					
			9					
			10					
			11					
			12					
			13					
			14					
			15					

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

SIGNED: DENTIST: \_\_\_\_\_ Date \_\_\_\_\_

Administered by: A.T.P.A. \_\_\_\_\_

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	