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 ☐ HANDICAPPED ☐ STUDENT | IF STUDENT INDICATE NAME AND ADDRESS OF SCHOOL

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 | MAILING ADDRESS | CITY STATE ZIP

IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
ARE ANY SERVICES COVERED BY ANOTHER PLAN?			

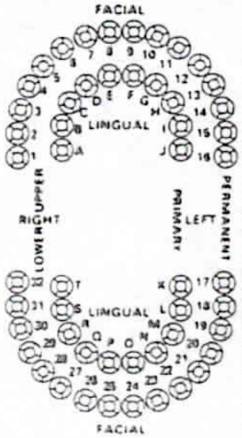
DENTIST SOC. SEC. OR T.I.N. | DENTIST LICENSE NO. | DENTIST PHONE NO.

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



REMARKS FOR UNUSUAL SERVICES

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

FOR ADMINISTRATION USE ONLY ☐ SCHEDULE ☐ U&C

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	%	%
		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			