United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund
1300 Higgins Road, Suite 300 ♦ Park Ridge, IL 60068-5713 ♦ 847-384-7000 ♦ 800-621-5133
CLAIMS OFFICE FAX 847-384-0196 ♦ TDD 847-384-0199 ♦ ufcwmidwest.org

Dental Claim Form

Instructions for Employee-Member

You complete the front of the form; your dentist completes the reverse; return the completed form to the above address. You may use this form or substitute a similar form from your dentist.

Pre-Treatment Estimate—Before you begin dental treatment, you may request an estimate of the benefits payable for the proposed treatment. You and your dentist complete this form, mark the box "Pre-Treatment Estimate" and return to the above address. The Benefits Office will determine benefits and will forward the estimate to your dentist and to you.

Employee-Member and Claim Information—Receipt of this claim form does not guarantee payment of benefits

1. YOUR FULL NAME (EMPLOYEE-MEMBER) | MAIDEN NAME | UFCW ID# or SOCIAL SECURITY NUMBER

2. STREET ADDRESS | CITY | STATE | ZIP | CHECK ☑ IF NEW ADDRESS ☐

3. DAYTIME AREA CODE/PHONE NUMBER | UFCW EMPLOYER NAME | ☐ MALE ☐ FEMALE | DATE OF BIRTH | ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED ☐ SEPARATED | DATE MARRIED

4. NAME AND ADDRESS OF ANY NON-UFCW COMPANY WHERE YOU ARE ALSO EMPLOYED

5. IS ANY PART OF TREATMENT DUE TO AN ACCIDENT? ☐ YES ☐ NO | IS ANY PART OF TREATMENT DUE TO PATIENT'S OCCUPATION? ☐ YES ☐ NO

Spouse (or other Parent if claim is for Dependent Child) Information—Complete for all Claims

6. FULL NAME OF SPOUSE OR PARENT | RELATIONSHIP | DATE OF BIRTH | SOCIAL SECURITY NUMBER

7. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS | CITY | STATE | ZIP | IS SPOUSE OR PARENT EMPLOYED? ☐ YES ☐ NO

8. NAME AND ADDRESS OF SPOUSE OR PARENT'S EMPLOYER (OR FORMER EMPLOYER) | AREA CODE/PHONE NUMBER

9. IS PATIENT COVERED UNDER ANY OTHER GROUP INSURANCE OR BENEFIT PLAN WHICH MAY ALSO PAY ANY EXPENSES ON THIS CLAIM? IF "YES," PROVIDE THE INFORMATION REQUESTED BELOW REGARDING THE OTHER PLAN. ☐ YES ☐ NO

10. NAME OF PLAN OR COMPANY | POLICY NUMBER

11. ADDRESS | CITY | STATE | ZIP | AREA CODE/PHONE NUMBER

Dependent Information—Complete Only if Claim is for a Dependent

12. DEPENDENT'S FULL NAME—FIRST AND LAST NAME | RELATIONSHIP | DATE OF BIRTH | SOCIAL SECURITY NUMBER

13. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS | CITY | STATE | ZIP

14. EMPLOYER NAME AND ADDRESS | CHECK ☑ IF NOT EMPLOYED ☐

15. IF CHILD, IS CHILD MARRIED? ☐ YES ☐ NO | IF CHILD OVER 18 YEARS, IS CHILD A FULL-TIME STUDENT? ☐ YES ☐ NO
IF "YES," SUBMIT EVIDENCE OF STUDENT STATUS DURING THE SEMESTER WHEN EXPENSE WAS INCURRED (E.G., LETTER FROM THE SCHOOL)

Signatures—Employee-Member and Patient (or Parent, if patient is a minor) must sign or benefits cannot be paid

I certify that the above answers and statements, including any accompanying statements, are true and complete to the best of my knowledge and belief. I authorize any dentist, physician, medical examiner or practitioner, coroner, hospital, Veterans Administration Hospital, clinic, other medical or medical-related facility, insurance or reinsuring company, consumer reporting agency, employer, school, or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the patient for whom claim is made, to give to United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund or its legal representative, any and all such information. A photocopy of this authorization shall be as valid as the original.

Date ________________ Signature ______________________________ ☞ **Employee-Member** sign here

Date ________________ Signature ______________________________ ☞ **Patient** (or Parent) sign here

Assignment of Benefits: Authorization to Pay Benefits to Dentist—Sign only if benefits to be paid directly to service provider

I hereby authorize payment directly to the dentist for any Dental Benefits otherwise payable to me for services in connection with this claim.

Date ________________ Employee-Member Signature ______________________________

— Your Dentist should complete the reverse side —

Attending Dentist's Statement

Use this form or attach a similar form of your own

Do not send radiographs or models unless specifically requested by the Benefits Office

EMPLOYEE-MEMBER NAME	UFCW ID# or SOCIAL SECURITY NUMBER	PATIENT NAME

DENTIST NAME	DEGREE
MAILING ADDRESS	
CITY, STATE, ZIP	
DENTIST PHONE NO ( )	DENTIST LICENSE NO

TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER

MUST BE FURNISHED UNDER AUTHORITY OF LAW

CHECK ONE:

☐ **DENTIST'S PRE-TREATMENT ESTIMATE**

☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

	NO	YES	
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) / DATE OF PRIOR PLACEMENT
IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER / DATE APPLIANCES PLACED / MOS TREATMENT REMAINING

FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT: OFFICE	HOSP.	ECF	OTHER	RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY?

IDENTIFY MISSING TEETH WITH "X"

FACIAL — LINGUAL — RIGHT — LEFT — UPPER — LOWER — PRIMARY — PERMANENT — FACIAL

Teeth: 1–32 (permanent), A–T (primary)

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

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YEAR	ADA PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

IF PERIODONTIAL TREATMENT, INDICATE ADA CASE TYPE

☐ 04500 TYPE I

☐ 04600 TYPE II

☐ 04700 TYPE III

☐ 04800 TYPE IV

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

► ______________________ SIGNED (DENTIST) DATE ____________

TOTAL FEE CHARGED	
AMOUNT PAID	
BALANCE DUE	