# SOUTHWEST CARPENTERS HEALTH & WELFARE TRUST

P.O. Box 17973 / Los Angeles, CA 90017-0973
(213) 385-0551

# DENTAL CLAIM FORM

## PATIENT & MEMBER INFORMATION (To be completed by Member) (PLEASE TYPE OR PRINT)

MEMBER NAME (First, Middle Initial, Last)

MEMBER'S S.S. NO.

UNION LOCAL NO.

FOR TRUST OFFICE USE ONLY

MEMBER'S ADDRESS (Street, City, State, Zip Code)

TELEPHONE # (_____) _____

IS SPOUSE EMPLOYED? ☐ Yes ☐ No

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____

PATIENT'S NAME (First, Middle Initial, Last)

PATIENT'S DATE OF BIRTH
Mo. Day Yr.

FULL TIME STUDENT (Complete only if claim for child, age 19 - 23)
☐ Yes ☐ No IF YES, WHERE

Patient's Address (If Different from Member)

PATIENT'S SEX
☐ Male ☐ Female

PATIENT'S RELATIONSHIP TO MEMBER
☐ Self ☐ Spouse ☐ Child ☐ Other

IS PATIENT COVERED UNDER OTHER DENTAL BENEFIT PLAN? ☐ Yes ☐ No
IF YES, CHECK TYPE ☐ Group ☐ Private
ENTER PLAN NAME AND ADDRESS OF CLAIMS OFFICES:

CERTIFICATE # _____ GROUP# _____

WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT?
☐ Yes ☐ No
B. AN ACCIDENT?
☐ Yes ☐ No

IF AN ACCIDENT ☐ A.M.
DATE _____ 20 _____ AND TIME _____ ☐ P.M.
SPECIFIC DESCRIPTION OF HOW AND WHERE ACCIDENT OCCURRED.

**PLAN MEMBER AND MEMBER'S SPOUSE PLEASE READ AND SIGN ON REVERSE SIDE.**

I AUTHORIZE PAYMENT OF AVAILABLE BENEFITS TO UNDERSIGNED DENTIST OR SUPPLIER.

SIGNED (Member or Authorized Person - Date)

## DENTIST INFORMATION (To be completed by Dentist)

DENTIST NAME PHONE#

FIRST VISIT DATE CURRENT SERIES

PLACE OF TREATMENT: OFFICE | HOSP. | ECS | OTHER

RADIOGRAPHS OR MODELS ENCLOSED? **SEE BELOW **** NO YES HOW MANY?

MAILING ADDRESS

IF PROSTHESIS, IS THIS INITIAL PLACEMENT NO YES (IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT

CITY STATE ZIP

IS TREATMENT FOR ORTHODONTICS? IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

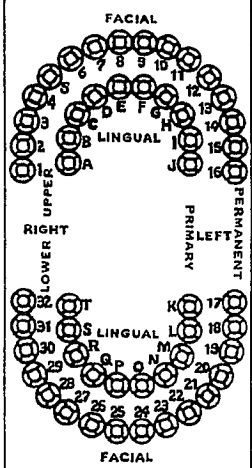
DENTIST SOC. SEC. OR T.I. NO. DENTIST LICENSE NO. GENERAL ANESTHESIA CERTIFICATE #

**PRE-DETERMINATION IS REQUIRED ON TREATMENT OVER $500.00**

## ☐ DENTIST STATEMENT OF ACTUAL SERVICES

** Please send X-Rays if services include crowns, prosthesis, root canals, or requested by seperate letter.

IDENTIFY MISSING TEETH WITH "X"




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 SERVICE INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC. | DATE SERVICE PERFORMED MO | DAY | YR. | | PROCEDURE NUMBER | FEE | |
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REMARKS FOR UNUSUAL SERVICES

LEAVE BLANK

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

SIGNED (DENTIST) DATE

TOTAL FEE CHARGED $

AMOUNT PAID $

BALANCE DUE $

HW-DC-01 8/04 5M

SEE OTHER SIDE

# SOUTHWEST CARPENTERS
# HEALTH AND WELFARE TRUST

## INSTRUCTIONS TO PLAN MEMBER

You and your spouse must sign a separate authorization for release of information before we can process claims for you, your spouse or your eligible minor children. No payment can be made until you have returned this signed authorization.

## AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer, union or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, my spouse or my minor children to give to the Trust shown on this letterhead (hereinafter called the Plan) or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by the Plan, its Trustees or its authorized claims paying administrator to determine eligibility for benefits or services under the Plan. Any information obtained will not be released by the Plan to any person or organization EXCEPT as specifically provided in the next paragraph or to reinsuring companies, the Medical Information Bureau, Inc., group policyholder, contractholder or other persons of organizations performing direct administrative, professional, medical or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I AUTHORIZE the Plan, the Trustees or the Plan's authorized claims paying administrator to release to anyone any information, with respect to me, my spouse or my minor children which the Plan deems necessary because of the Coordination of Benefits provision contained in the Rules and Regulations of the Plan.

I UNDERSTAND that I may request to receive a copy of this Authorization.

I AGREE this Authorization shall be valid for the duration of my coverage under this Plan or through the third calendar year from the date shown below whichever is later.

Signed this _____ of _____, 20_____
DAY MONTH YEAR

Plan Member's Social Security Number _____

_____ _____
PRINT NAME OF PLAN MEMBER PRINT NAME OF PLAN MEMBER'S SPOUSE

_____ _____
SIGNATURE OF PLAN MEMBER SIGNATURE OF PLAN MEMBER'S SPOUSE

NOTE TO DOCTOR OR PROVIDER: If claim is submitted on a form other than the Carpenter's Health and Welfare Trust claim form, this authorization must be attached to the claim form and given to the patient or sent to the Trust. If you wish, you may copy the authorization.