DENTAL CARE BENEFITS FORM

RETURN COMPLETED FORM TO:

Cement Masons and Plasterers Local 518 Welfare Fund
6405 Metcalf Avenue, Suite 200
Overland Park, KS 66202

EMPLOYEE INFORMATION – *Required For All Claims*

EMPLOYEE'S NAME *(Last, First, Middle)*	DATE OF BIRTH	SOCIAL SECURITY NUMBER

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED	PHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP

OCCUPATION ☐ ACTIVE ☐ RETIRED	HOME LOCAL UNION NUMBER

DEPENDENT INFORMATION – *If Claim Is For Your Dependent*

DEPENDENT'S NAME *(Last, First, Middle)*	DATE OF BIRTH	SOCIAL SECURITY NUMBER

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED	RELATIONSHIP TO EMPLOYEE

STREET ADDRESS	CITY	STATE	ZIP

IS DEPENDENT EMPLOYED? ☐ YES ☐ NO	IF YES, COMPANY NAME

COMPANY STREET ADDRESS	CITY	STATE	ZIP

IS DEPENDENT ATTENDING SCHOOL ☐ YES ☐ NO	IF YES, SCHOOL NAME

SCHOOL STREET ADDRESS	CITY	STATE	ZIP

OTHER INSURANCE INFORMATION

DO YOU OR YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL INSURANCE?

☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING INFORMATION:

NAME OF THE PERSON INSURED	RELATIONSHIP TO EMPLOYEE
INSURED PERSON'S EMPLOYER	PHONE NUMBER

EMPLOYER STREET ADDRESS	CITY	STATE	ZIP

POLICY NUMBER	CERTIFICATE NUMBER	SOCIAL SECURITY NUMBER

NOTE: Attach a copy of payment worksheet or denial from other insurance.

ACCIDENT INFORMATION

If this treatment was required due to an accidental injury, please complete the Accidental Information Section on the other side of this form.

AUTHORIZATION

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when required by the Trustees or their representative, of any facts concerning the treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee's Signature *Date*

Patient's Signature *Date*

ASSIGNMENT

I hereby authorize payment of Dental Benefits directly to the provider of services and materials described on the reverse side of this form.

Employee's Signature *Date*

YOU MUST SIGN FORM ON THE REVERSE SIDE

ACCIDENT INFORMATION

NATURE OF INJURY	DATE ACCIDENT OCCURRED	DATE FIRST TREATED

NAME AND ADDRESS OF PHYSICIAN(S) CONSULTED

(1)

(2)

IF HOSPITALIZED, NAME OF HOSPITAL	DATE ADMITTED	DATE DISCHARGED

IF INJURED, **HOW** AND **WHERE** DID ACCIDENT HAPPEN?

DID INJURY OCCUR IN THE COURSE OF ANY EMPLOYMENT?	IF YES, HAVE YOU OR DO YOU INTEND TO FILE A WORK COMP CLAIM?
☐ YES ☐ NO	☐ YES ☐ NO

TO BE COMPLETED BY DENTIST – *Use the Nomenclature and Procedure Codes Provided*

PATIENT'S NAME	AGE

DENTIST'S NAME	IS TREATMENT RESULT OF OCCUPATIONAL INJURY OR ILLNESS?	☐YES ☐NO	IF YES, ENTER DESCRIPTION AND DATES
ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?	☐YES ☐NO	IF YES, ENTER DESCRIPTION AND DATES
CITY / STATE / ZIP	ARE ANY SERVICES COVERED BY ANOTHER INSURANCE PLAN?	☐YES ☐NO	IF YES, ENTER OTHER INSURANCE INFO
SSN OR TAX ID # / LICENSE # / PHONE #	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	☐YES ☐NO	IF NO, REASON FOR REPLACEMENT / DATE OF PRIOR PLACEMENT
FIRST VISIT DATE / PLACE OF TREATMENT ☐OFFICE ☐HOSPITAL ☐EOF ☐OTHER:____________________	IS TREATMENT FOR ORTHODONTICS?	☐YES ☐NO	IF ORTHODONTIC SERVICES ALREADY COMMENCED, PLEASE ENTER: DATE APPLIANCES PLACED / MONTHS OF TREATMENT REMAINING

RADIOGRAPHS OR MODELS ENCLOSED: ☐YES ☐NO QUANTITY: ________________

NO PRE-ESTIMATE REQUIRED

INDICATE MISSING TEETH WITH AN "X"

LABIAL
UPPER RIGHT LINGUAL LEFT PRIMARY PERMANENT
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
A B C D E F G H I J
LOWER LINGUAL
K L M N O P Q R S T
17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
LABIAL

IF NONE, CHECK BOX ☐

EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO 1 THROUGH 22. USE CHARTING SYSTEM SHOWN.

FOR FUND USE ONLY: ☐SCHEDULED ☐USUAL & CUSTOMARY

TOOTH &/OR LETTER	SURFACE	DESCRIPTION OF SERVICES	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE

ORTHODONTICS *(Give diagnosis, glass of malocclusion and describe appliances)*

DATE FIRST APPLIANCE INSERTED	DATE LAST APPLIANCE REMOVED	TREATMENT PERIOD (# OF MONTHS)

TOTAL FEE $

TOTAL				
DEDUCTIBLE				
TOTAL COVERED				
COPAYMENT	%	%	%	%
TOTAL				
FUND PAYS				
PATIENT PAYS				

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE DATES INDICATED.

DENTIST'S SIGNATURE: DATE:

I HEREBY CERTIFY THAT I HAVE REVIEWED THE PLAN OF TREATMENT AND THE FEES TO BE CHANGED AND UNDERSTAND THAT I AM FINANCIAL RESPONSIBLE FOR THE CHARGES NOT COVERED BY THE PLAN.

EMPLOYEE'S SIGNATURE DATE

PATIENT MUST BE ELIGIBLE ON DATE SERVICES PERFORMED.
If treatment extends beyond this date you must verify eligibility with the Fund Office.