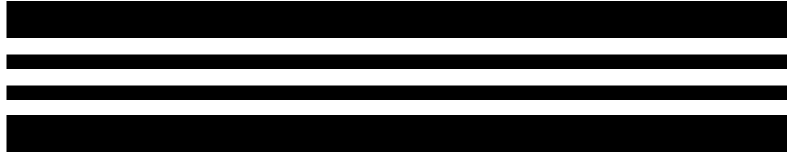

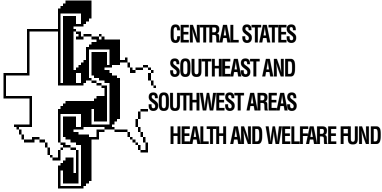

MAIL TO:

Central States Southeast and Southwest Areas
Health and Welfare Fund
Claims Processing – Dental

PO Box 5104 Des Plaines IL 60017-5104
1-800-323-5000

DO NOT WRITE ABOVE THIS LINE.
FOR OFFICE USE ONLY.

PART 1 MEMBER – READ INSTRUCTIONS ON BACK BEFORE COMPLETING PART 1.

Member's Soc. Security Number	Member's First Name	Middle Initial	Last Name	Member's Birth Date (Month / Day / Year)	Sex
					☐ M ☐ F

IF ADDRESS HAS CHANGED SINCE LAST CLAIM, PLACE "X" IN THIS BOX. ☐	Member's Street Address	Member's City & State	Zip Code

Local Union	Employer Name	Member's Marital Status
		☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient's First and Last Name	Relationship To Member	Patient's Birthdate (Month / Day / Year)	Is Patient covered by other Group Dental Plan?
	☐ Self ☐ Son ☐ Stepson ☐ Stepdaughter ☐ Spouse ☐ Daughter ☐ Other (explain) ____		☐ YES ☐ NO

THESE QUESTIONS MUST BE ANSWERED!	First Name of Spouse	Is your Spouse employed?	Does your Spouse have Group Dental coverage?	Spouse's Soc. Sec. Number	Spouse's Birthdate (Month / Day / Year)
		☐ Yes ☐ No	☐ Yes ☐ No		

Spouse's Employer Providing Coverage	Address of Spouse's Employer (Street, City, State, & Zip Code)

Spouse's Insurance Company Name & Address (Street, City, State, & Zip Code)	Group Number	Policy Number

AUTHORIZATION

I hereby authorize release of any x-rays and information relating to this claim.

SIGNED (Patient, or Parent if Minor) **Date**

ASSIGNMENT OF BENEFITS SIGN ONLY AFTER WORK HAS BEEN COMPLETED.

I hereby certify that services listed below have been **fully completed and delivered** and I authorize benefit payment directly on the below-named dentist.

SIGNED (Member) **Date**

PART 2 DENTIST – READ INSTRUCTIONS ON BACK BEFORE COMPLETING PART 2.

Dentist Name (Indicate Specialty, if any)			Is treatment result of occupational illness or injury?	☐ YES ☐ NO	If YES, enter a brief description and dates.
Mailing Address			Is treatment result of auto accident or other accident?	☐ YES ☐ NO	
City, State, Zip			Are any services covered by another plan?	☐ YES ☐ NO	
Dentist Tax I.D. Number/or S.S. No. *	Dentist Lic. No.	Dentist Phone No. ( )	If Prosthesis, is this initial placement?	☐ YES ☐ NO	If NO, reason for Re-placement. / Date of prior placement
First visit date Current Series	Place of Treatment Office ☐ Hosp. ☐ ECF ☐ Other ☐	Radiographs or Models enclosed? ☐ YES ☐ NO / How many?	Is treatment for Orthodontics?	☐ YES ☐ NO	If service already commenced enter date appliances placed. / Mos. treatment remaining.

CHECK ONE:

☐ Pre-determination Estimate

☐ Statement of Actual Services

TOOTH CHART

Indicate Teeth being Replaced by Partial(s)

INDICATE MISSING TEETH WITH AN X

EXAMINATION and TREATMENT - List in order from tooth no. 1 through no. 32 - Use charting system shown.

Tooth No. or Letter	Surface	DESCRIPTION OF SERVICE (Including X-rays, Prophylaxis, materials used, etc.)	Date Service Completed Mo Day Year	Procedure Number (ADA CODE)	FEE	For Office Use Only
		Benefits are Based on the insertion (not preparation) date of the following: Full & Partial Dentures, Crowns & Bridgework.				
				TOTAL FEE	$	

FOR OFFICE USE ONLY

☐ DIAG. ☐ ORTHO. ________ ☐ F.B. ________

☐ POST. ☐ ALT. TR. ________

Date ________ D. Consultant ________

FOR OFFICE USE ONLY

PART 3 – DENTIST TO SIGN ONLY AFTER WORK HAS BEEN COMPLETED.

I hereby certify that services listed above have been fully completed and delivered to the named patient on the dates indicated and that the fees shown are those currently charged to the majority of my patients. I also authorize Central States Health & Welfare Fund or its representatives to examine all accounts and records pertaining to this patient.

Signed Dentist ________________ Date ________

In order to expedite processing of this claim, include periapical x-rays for any inlays, crowns, bridgework, and root canals.

* Dentist Tax I.D. Number or Social Security Number must be furnished under authority of Law when benefits are assigned

MEMBER'S INSTRUCTIONS

Please Read Carefully

HOW TO FILE A CLAIM FOR DENTAL BENEFITS

One of the advantages of this Dental Plan is that you can find out how much will be paid by your Health & Welfare Fund **befc** you have the dentist do extensive work. This procedure, called "PRE-DETERMINATION OF BENEFITS," will:

1. Tell you the exact amount that is covered;
2. Explain any procedures that are not covered;
3. Enable you to estimate exactly what **your** portion of the dentist's charge may be upon completion of treatment.

Usually, before starting extensive work, the dentist will tell you what work needs to be done. By filing this form with the Clai Processing Agent before starting extensive treatment, it allows them to advise you in advance of the benefits allowable a your portion of the dentist's fee.

Since dental work can be expensive and it is to your advantage to know the benefits before you agree to have the work dor it is recommended that you ask your dentist to file for a "PRE-DETERMINATION OF BENEFITS" whenever the estimated char is **$150.00 OR MORE.**

NOTE: Each Pre-Determined Benefit will be paid only if you continue to be covered under this Plan for THAT date treatment. Remember, too, that all benefits to be paid are subject to the Annual Maximum and Coordination of Benel (COB) Provision in your Dental Plan.

COMPLETE THE CLAIM FORM AS FOLLOWS:

1. You **MUST** complete all items in PART 1. Recheck the Member's Social Security Number you have entered for accura

   NOTE: If the form is not properly completed, the claim will be delayed because the Claims Processing Agent will ha to request the missing information.
2. If you sign the box entitled "Assignment of Benefits," payment will be made directly to the dentist.

IF $150.00 OR MORE AND PRE-DETERMINATION OF BENEFITS IS REQUESTED

1. The dentist will complete Part 2 and send the form to the Claims Processing Agent.
2. Both you and your dentist will receive a copy of the Pre-Determination of Benefits form so that you may review the benef allowable and the services to be performed.
3. When work is completed, the dentist must return the Pre-Determination of Benefits form to the Claims Processing Age Both you and your dentist must sign the Pre-Determination of Benefits form indicating that work has been completed. Payme will be made to either you or your dentist, depending on whether you decide to assign benefits directly to the dentist. payment is made directly to the dentist, you will receive a copy of the benefit check and an Explanation of Benefits.

IF LESS THAN $150.00 OR FOR EMERGENCY TREATMENT OR PRE-DETERMINATION NOT REQUESTED

1. The dentist will complete Part 2 and send the form to the Claim Processing Agent.
2. Payment in the amount provided by the Plan will be made to either you or your dentist, depending on whether you sign the Assignment of Benefits authorizing payment directly to the dentist. If payment is made directly to the dentist, you will receive a copy of the benefit check and an Explanation of Benefits.

DENTIST'S INSTRUCTIONS

A. PRE-DETERMINATION OF BENEFITS

Pre-Determination of Benefits will help both you and your patient. The Pre-Determination program will inform all parties, before treatment, as to how much will be paid by the Health and Welfare Fund. This will avoid misunderstandings and enable you to make arrangements with the patient in advance for any amount that may be owed to you in addition to what is paid by the Health and Welfare Fund.

Pre-Determination of Benefits is not intended to interfere with your professional judgment. You should examine the patient and recommend the treatment plan that best suits the patient's needs. Normally, if the work is extensive, you will describe the proposed treatment and inform your patient of the charges. Pre-Determination of Benefits is simply a form on which you will furnish this information.

NOTE: Each Pre-Determined Benefit will be paid only if the Patient continues to be covered under this Plan for that date of treatment. Furthermore, all benefits to be paid are subject to the Annual Maximum and Coordination of Benefits (COB) Provision in this Dental Plan.

Pre-Determination of Dental Benefits is suggested if charges will exceed $150.00.

B. HOW TO COMPLETE THE CLAIM FORM

1. **Complete Part 2 using the Nomenclature and Codes of the American Dental Association.**

   If the course of treatment includes crowns or any type of prosthesis, please indicate in the appropriate section of the claim form whether this is THE INITIAL OR A REPLACEMENT CROWN/PROSTHESIS.

   To expedite pre-determination and final payment, it is suggested that pre-treatment x-rays be submitted along with this form when the course of treatment includes gold restorations, crowns, or bridgework. X-rays may also be requested for other services. **They will be returned promptly.**
2. **Complete Part 3 — Sign and date the form.**
3. **Send form with any necessary pre-treatment x-rays to the address shown on the form for a Pre-Determination of Benefits, or for payment.** If this is a Pre-Determination of Benefits, a form will be sent to you indicating the benefits allowable for the course of treatment submitted.

SUPPLEMENTARY INSTRUCTIONS FOR ORTHODONTIC TREATMENT

Please supply the following information on the Dental Claim Form:

A. Class of Malocclusion.

B. Total charge for treatment.

C. Estimated length of active treatment.

D. Date initial appliance was or will be inserted.