Return completed form to:

I.A.T.S.E. Local #16 Health & Welfare Trust Fund
4160 Dublin Boulevard, Suite 400,
Dublin, CA 94568-7756.

Elig: _____

Claim # _____

ATTENDING DENTIST'S STATEMENT

— Dental Only —

1 PATIENT NAME	2 RELATIONSHIP TO EMPLOYEE Self / Spouse / Child / Other	3 SEX M / F	4 PATIENT BIRTHDATE MO / DAY / YEAR	5 IF FULL TIME STUDENT School / City
6 EMPLOYEE NAME First / Middle / Last	7 EMPLOYEE SOCIAL SECURITY NUMBER		9 NAME OF GROUP DENTAL PROGRAM	
8 EMPLOYEE MAILING ADDRESS	INSURED DATE OF BIRTH		10 EMPLOYER (COMPANY) NAME AND ADDRESS	
CITY, STATE, ZIP				

11 GROUP NUMBER	12 LOCATION (LOCAL)	13 ARE OTHER FAMILY MEMBERS EMPLOYED? YES ☐ NO ☐ EMPLOYEE NAME / SOC. SEC. NO.	SPOUSE DATE OF BIRTH	14 NAME AND ADDRESS OF EMPLOYER IN ITEM 13	
15 IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES ☐ NO ☐	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER	

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

_____
Signed (Patient, or Parent If Minor) *Date*

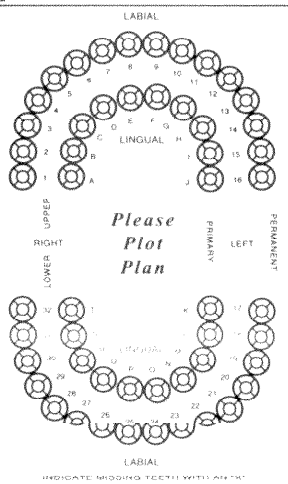
I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

_____
Signed (Insured Person) *Date*

DENTIST'S INFORMATION

16 DENTIST NAME	24 IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO ☐	YES ☐	If yes, enter brief description and dates
17 MAILING ADDRESS	25 IS TREATMENT RESULT OF AUTO ACCIDENT?	☐	☐	
	26 OTHER ACCIDENT?	☐	☐	
CITY, STATE, ZIP	27 ARE ANY SERVICES COVERED BY ANOTHER PLAN?	☐	☐	
18 DENTIST SOC. SEC. NO. OR T.I.N. 19 DENTIST LICENSE NO. 20 DENTIST PHONE NO.	28 IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	☐	☐	(If No, reason for replacement) 29 DATE OF PRIOR PLACEMENT
21 FIRST VISIT DATE CURRENT SERIES / 22 PLACE OF TREATMENT OFFICE HOSP ECS OTHER / 23 RADIOGRAPHS OR MODELS ENCLOSED? HOW MANY?	30 IS TREATMENT FOR ORTHODONTICS?	☐	☐	IF SERVICES ALREADY COMMENCED ▲ Date appliances placed / Months Treatment Remaining

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES



32 REMARKS FOR UNUSUAL SERVICES

31 EXAMINATION AND TREATMENT PLAN — List in order from Tooth No. 1 through Tooth No. 32 – USE CHARTING SYSTEM SHOWN.

Tooth # Or Letter	SURFACES	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc.)	DATE SERVICE PERFORMED Mo.	Day	Year	PROCEDURE NUMBER	FEE	ADMINISTRATIVE USE

I hereby certify that the procedures as indicated by date have been completed.

_____ Date _____
Signed (Dentist)

TOTAL FEE CHARGED	
Max. Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	

Carrier Use Only

Eligibility Verified By _____
Date _____
Claim Number _____

Pre-authorization is required for treatment plans in excess of $250.00. Submit with x-rays and perio charting.

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