Dental Claim Form

1. ☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
Provider TIN #:

2. Patient SS # (Last 4 Digits):

3. **IBEW-NECA Claims Administration**
Allied Administrators
P.O. Box 2500
San Francisco, CA 94126
(800) 736-0401

PATIENT COVERAGE INFO.

4. Patient's name
first m.i. last

5. Patient relationship to participant
☐ self ☐ child
☐ spouse ☐ other _____

6. Sex
M ☐ F ☐

7. Patient birthdate
MM DD YYYY

8. If full time student, please complete:
School
City
Tel. # # of units:

9. Participant name and mailing address

10. Participant S.S. #

11. Participant birthdate
MM DD YYYY

12. Participant phone #
( )

13. Employer name and address

14-a. Is patient covered by another dental plan?
☐ YES ☐ NO
14-b. Is patient covered by a medical plan?
☐ YES ☐ NO
If 14-a. or 14-b. is yes, complete 15-a. — 18

15-a. Name and address of carrier(s)

15-b. Group no.(s)

16. Name, address and phone number of other employer(s)

17-a. Participant name
(if different from patient's)

17-b. Participant S.S. #

17-c. Participant birthdate
MM DD YYYY

18. Participant relationship to patient
☐ self ☐ child
☐ spouse ☐ other _____

FOR PAYMENT —
Plan participant and dependents must be eligible at time services are rendered.

Participant's Signature X_____
Parent's Signature if patient is a minor

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Participant's Signature X_____
NOTE TO DENTIST: "SIGNATURE ON FILE" NOT ACCEPTABLE

I ACCEPT THE TREATMENT PLAN AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO. I CERTIFY THE TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED DURING ANY INELIGIBLE PERIOD.

Participant's Signature X_____ _____
NOTE TO DENTIST: "SIGNATURE ON FILE" NOT ACCEPTABLE Date Signed

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity

22. Address where payment should be remitted

23. City, State, Zip

24. Dentist Soc. Sec. or T.I.N.

25. Dentist license no.

26. Dentist phone no.

27. First visit date current series

28. Place of treatment
Office Hosp. ECF Other

29. Radiographs or models enclosed? No ☐ Yes ☐ How many?

30. Is treatment result of occupational illness or injury? No ☐ Yes ☐ If yes, enter brief description and dates.

31. Is treatment result of auto accident? No ☐ Yes ☐

32. Other accident? No ☐ Yes ☐

33. If prosthesis, is this initial replacement? No ☐ Yes ☐ If no, reason for replacement

34. Date of prior placement

34. Is treatment for orthodontics? No ☐ Yes ☐ If service already commenced, enter:
Date appliances placed _____
Months of treatment remaining _____

36. Identify missing teeth with "x".

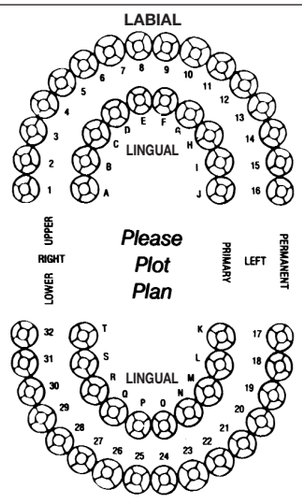

CHART WORK

37. **Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32 — Using charting system shown.**

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICES (including x-rays, prophylaxis, materials used, etc.)	DATE SERVICE PERFORMED MO.	DAY	YR.	ADA PROCEDURE NUMBER	FEE		ADMINISTRATIVE USE ONLY

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE DATE(S) SHOWN ABOVE.

DENTIST'S SIGNATURE _____ DATE _____

PREAUTHORIZATION is required for gold or porcelain restorations, inlays and crowns and/or any treatment over $500.00. Submit x-rays with this form before services are rendered. X-rays will be returned to you. Services not authorized will be marked "NO" and services authorized will be left blank in the right hand column.

PLEASE NOTE: THIS FUND PAYS 100% OF ENCLOSED SCHEDULE-UP TO $2,000.00 ANNUAL MAXIMUM SUBJECT TO ELIGIBILITY WHEN SERVICES ARE RENDERED.

Total Fee		
Allowable Fee		
Benefits Covered by Our Plan		
Payable by Other Plan	1.	
Balance not Payable by Other Plan		
To or From Benefit Reserve	2.	
Total Paid by Our Plan		
X-RAYS have been reviewed and returned Initials_____ Date_____	3.	

WHITE: DENTAL PLAN ORIGINAL YELLOW: DENTIST'S COPY

® GCIU 1120-M