RETURN COMPLETED FORM TO:

BAC LOCAL UNION 15

WELFARE FUND

6405 Metcalf, Suite 200 • Overland Park, Kansas 66202
(913) 236-5490 • Fax: (913) 236-5499

Dental Care Form

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

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

STREET ADDRESS	CITY	STATE	ZIP

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

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:

A) NAME OF THE PERSON INSURED	RELATIONSHIP TO EMPLOYEE
B) INSURED PERSON'S EMPLOYER	PHONE NUMBER ( )

C) EMPLOYER'S STREET ADDRESS	CITY	STATE	ZIP

D) POLICY NUMBER	CERTIFICATE NUMBER	SOCIAL SECURITY NUMBER

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

ACCIDENT INFORMATION

If this treatment was required due to accidental injury, please complete Accidental Information section on 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 requested 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 & ADDRESS OF PHYSICIAN(S) CONSULTED

(1)

(2)

IF HOSPITALIZED, NAME OF HOSPITAL | DATE ADMITTED | DATE DISCHARGED

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

DID INJURY OCCUR IN THE COURSE OF ANY EMPLOYMENT? ☐ YES ☐ NO

HAVE YOU OR DO YOU INTEND TO FILE THIS CLAIM UNDER WORKER'S COMPENSATION? ☐ 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 ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES	
ADDRESS			IS TREATMENT RESULT OF AUTO ACCIDENT?				
			OTHER ACCIDENT?				
CITY / STATE / ZIP			ARE ANY SERVICES COVERED BY ANOTHER PLAN?				
DENTIST SS OR TAX ID NO.	DENTIST LICENSE NO.	DENTIST PHONE NO.	IF PROTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT	DATE OF PRIOR PLACEMENT
FIRST VISIT DATE	PLACE OF TREATMENT: OFFICE / HOSP. / ECF / OTHER	RADIOGRAPHS OR MODELS ENCLOSED ☐ YES ☐ NO QTY. ____	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCES PLACED	MO. TREATMENT REMAINING

NO PRE-ESTIMATE REQUIRED

INDICATE MISSING TEETH WITH AN "X"

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

IF NONE, CHECK BOX ☐

FOR FUND USE ONLY ☐ SCHEDULED ☐ USUAL & CUSTOMARY

EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO.1 THROUGH 32
USE CHARTING SYSTEM SHOWN

TOOTH & OR LETTER	SURFACE	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE				

ORTHODONTICS: *(Give Diagnosis, Class of Malocclusion and Describe Appliance(s) in Above Treatment Section)*

DATE FIRST APPLIANCE INSERTED	DATE LAST APPLIANCE REMOVED	TREATMENT PERIOD (NUMBER 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 CHARGED AND UNDERSTAND THAT I AM FINANCIALLY 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 FURTHER ELIGIBILITY WITH CLAIMS OFFICE.