

ATTENDING DENTIST'S STATEMENT

TREATMENT PLAN AND BENEFIT CLAIM REPORT

When Completed Return Form To:

IBEW/NECA SOUND & COMMUNICATIONS

P.O. Box 5057
San Jose, California 95150-5057
(408) 288-4400

CHECK ONE: FOR PRE-DETERMINATION
 FOR PAYMENT

SHADED AREA FOR ADMINISTRATION USE ONLY

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1. EMPLOYEE NAME		7. SOC. SEC. NO.	8. CLASS		9. INCURRED		10. PLAN NO.		
2. 3. MAILING ADDRESS - STREET		11. LOCAL		12. ISSUED MO. DAY YR.		13.		14. INS. CO.	
4. CITY		5. STATE		6. ZIP		15. AMOUNT CHARGE		16. AMOUNT C.O.B.	
18. PATIENT'S NAME		RELATIONSHIP TO EMPLOYEE		19. SEX M <input type="checkbox"/> F <input type="checkbox"/>		20. PATIENT'S B'DATE MO. DAY YR.		21. DATE FIRST VISIT MO. DAY YR.	
17. BALANCE DUE		COORDINATION OF BENEFITS		15. AMOUNT CHARGE		16. AMOUNT C.O.B.		17. BALANCE DUE	

15. IS PATIENT COVERED BY OTHER DENTAL PLAN?
YES NO IF YES, ANSWER THESE QUESTIONS →

NAME OF SPOUSE	SPOUSE'S SOC. SEC. NO.
NAME OF DENTAL PLAN AND ADDRESS	
GROUP, POLICY OR UNION NO.	

TO BE COMPLETED BY SPOUSE: I HEREBY AUTHORIZE ANY UNION, TRUST FUND, EMPLOYER, OR INSURANCE COMPANY TO FURNISH UNITED ADMINISTRATIVE SERVICES WITH INFORMATION REGARDING BENEFITS TO WHICH I/WE MAY BE ENTITLED.

SIGNED (SPOUSE) _____ DATE _____

22. DENTIST'S NAME		23. LIC. NO.	DENTIST SOC. SEC. NO. OR IRS EMP. IDENT. NUMBER	24. S	25. E
26. 27. MAILING ADDRESS - STREET		PHONE	IF PROSTHESIS, IS THIS INITIAL REPLACEMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		
28. CITY		29. STATE	30. ZIP	IF NO, REASON FOR REPLACEMENT	
				DATE PRIOR REPLACEMENT	

X-RAYS ENCLOSED YES NO IF YES, HOW MANY?

IS TREATMENT FOR ORTHODONTIC PURPOSES? YES NO RESULT OF ACCIDENT? YES NO OCCUPATIONAL INJURY? YES NO

TOOTH LETTERS	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS, ETC.)	31. PROCEDURE NUMBER	32. DATE OF SERVICE MO. DAY YR.	33. FEE	34. C.C.	35. AMOUNT CERTIFIED
							36.
							37.

I HEREBY ACCEPT THIS TREATMENT PLAN AND AUTHORIZE RELEASE OF INFORMATION ON THIS CLAIM.

SIGNED (EMPLOYEE) _____

I HEREBY AUTHORIZE PAYMENT TO THE ABOVE NAMED DENTIST OF BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN ABOVE. I UNDERSTAND I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

SIGNED (ELIGIBLE EMPLOYEE) _____ DATE _____

I CERTIFY THAT SERVICES LISTED HAVE BEEN PERFORMED AND PAYMENT IS THEREFORE DUE.

SIGNED (DENTIST) _____

DEDUCTIBLE (IF ANY)	38.
COINSURANCE (PAYABLE AT)	39.
TOTAL PAYMENT THIS AUDIT	40.
41. DRAFT NO.	