PLAN 45D

DENTAL CLAIM

ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST

EMPLOYEE STATEMENT

☐ **Check here if your address is new.**

PART 1 – EMPLOYEE INFORMATION

EMPLOYEE NAME – First Initial Last	☐ M ☐ F	EMPLOYEE WPAS ID# or SSN	EMPLOYEE BIRTH DATE Mo. Day Year

HOME ADDRESS STREET	CITY	STATE	ZIP	PHONE

EMPLOYED BY	LOCAL No.

PATIENT'S NAME – First Initial Last	☐ M ☐ F	PATIENT SOCIAL SECURITY NO.	PATIENT BIRTH DATE Mo. Day Year	RELATION TO EMPLOYEE ☐ Self ☐ Spouse ☐ Child

EMPLOYEE MARTIAL STATUS
☐ MARRIED ☐ LEGAL SEP.
☐ SINGLE
☐ WIDOWED
☐ DIVOCED

IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU
☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ FOSTER CHILD
☐ STEP CHILD ☐ GUARDIANSHIP
☐ OTHER (EXPLAIN) ___________________________________

IF DEPENDENT CHILD IS AGE 19 OR OLDER, DOES HE/SHE HAVE ACCESS TO INSURANCE THROUGH HIS/HER EMPLOYMENT? ☐ YES ☐ NO
IF YES, WAS COVERAGE DELCLINED? ☐ YES ☐ NO

DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? ☐ YES ☐ NO

NAME OF SPOUSE (if not patient listed above)	SPOUSE BIRTH DATE Mo. Day Year	SPOUSE SOCIAL SECURITY NO.

IS SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME & ADDRESS SPOUSE'S EMPLOYER	DOES SPOUSE'S EMPLOYER OFFER GROUP HEALTH INSURANCE? ☐ YES ☐ NO DID SPOUSE DECLINE THAT COVERAGE? ☐ YES ☐ NO

PART 2 – INSURANCE INFORMATION

ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? ☐ YES ☐ NO

IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER NAME __________________________________ ADDRESS__________________________________

NAME OF SUBSCRIBER ____ SUBSCRIBER ID # OR SOCIAL SECURITY NO. _________________

OTHER GROUP PLAN COVERS: ☐ PATIENT ☐ SPOUSE ☐ CHILDREN OTHER GROUP PLAN POLICY OR ID #_________________________________

OTHER GROUP PLAN INCLUDES: ☐ MEDICAL ☐ DENTAL ☐ VISION

ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? ☐ YES ☐ NO IF "YES", NAME OF COVERED PERSON _____________________________

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY AUTHORIZE MY DOCTOR TO FURNISH AND DISCLOSE ALL FACTS CONCERNING THE CLAIM.

EMPLOYEE'S SIGNATURE X ____ **DATE** _____/_____/_____

PROCEDURE FOR FILING A CLAIM

INSTRUCTIONS TO THE EMPLOYEE:

1. Complete all applicable sections of Part 1-Employee Information and Part 2-Insurance Information. Failure to properly complete these sections may result in a delay in processing your claim.
2. Be sure to sign where indicated on Part 2. If you want the dental benefit payment sent directly to your dentist, sign on the bottom line of Part 3 (see reverse side of this form).
3. Complete a separate form for each patient.
4. Take this form to your dentist on your first visit. Upon completion of treatment complete and forward the form to the address below.

INSTRUCTIONS TO THE DENTIST:

1. **Predetermination of cost is not required.**
2. Complete Part 3-Dentist Information, answer all questions and indicate all treatment performed.
3. Indicate on the chart all missing teeth with an "X" and all abutments with an "O".
4. Describe procedures for treatment of this case, give the date of service and the fee charged for each procedure. The use of the standard ADA codes will expedite the processing of this claim.
5. For payment to be made directly to the dentist, the **employee must sign the bottom line on the reverse side of this form.**

Upon completion of treatment, return this form to:

AK UFCW TRUST
P.O. BOX 34945
Seattle Washington 98124-1945
Phone: (206) 441-7574 or 1-800-331-6158

NOTE: If you have other Group Insurance as your primary coverage, you need to submit the itemized bill AND a copy of the matching insurance payment explanation.

PART 3 – DENTIST INFORMATION

DENTIST NAME	TELEPHONE NUMBER	IS PATIENT COVERED BY ANOTHER PLAN? IF "YES", ENTER NAME OF OTHER PLAN	YES	NO
DENTIST MAILING ADDRESS				
CITY / STATE / ZIP		IS ANY OF THE TREATMENT FOR ORTHODONTIC PURPOSES?		
YOUR TAX IDENTIFICATION NUMBER		TREATMENT RESULT OF ACCIDENT?		
OTHER WISE YOUR SOC. SEC. NO.		TREATMENT RESULT OF OCCUPATIONAL INJURY?		
(MUST BE FURNISHED UNDER AUTHORITY OF LAW)		ARE X-RAYS ENCLOSED? IF "YES", HOW MANY?		

IF PROSTHESIS, IS THIS INITIAL?	YES	NO	IF "NO", REASON FOR REPLACEMENT	DATE PRIOR PLACEMENT MO. DAY YEAR

CHECK ONE

☐ DENTIST'S PRETREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

(WORK COMPLETED – PAYMENT REQUESTED)
THE TREATMENT LISTED BELOW WAS COMPLETED AND WAS NECESSARY IN MY JUDGEMENT.

DENTIST SIGNATURE DATE

EXAMINATION AND TREATMENT RECORD

DATE FIRST VISIT (CURRENT SERIES) MO. DAY YEAR	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	NO. OF X-RAYS ETC.	ADA PROCEDURE NUMBER	DATE SERVICE PERFORMED MO. DAY. YEAR	FEE	ADMIN. USE ONLY
IDENTIFY MISSING TEETH WITH "X" AND ABUTMENTS WITH AN "O"								
Facial; Upper; Right; Lingual; Primary; Permanent; Left; Lower; Lingual; Facial								

PATIENT NAME

IF PARTIAL/DENTURE – INDICATE IMPRESSION DATE: ______________________________ DELIVERY: ______________

IF PROSTESIS OR CROWN – INDICATE PREP DATE: __________________________ SEAT: ______________________

IF ROOT CANAL – INDICATE START DATE: __________________________________ FINISH: ______________________

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

EMPLOYEE SIGNATURE X ____ **DATE:**____________________

SEE OTHER SIDE FOR INSTRUCTIONS FOR FILING A CLAIM

BENEFIT, CLAIMS PAYMENT AND ELIGIBILITY INFORMATION MAY BE OBTAINED FROM:
WELFARE & PENSION ADMINISTRATION SERVICE, INC.
PHONE: (206) 441-7574 or 1-800-331-6158
www.akufcwtrust.com

ELIGIBILITY INFORMATION MAY ALSO BE OBTAINED FROM:
LABOR TRUST SERVICES
ANCHORAGE, ALASKA
PHONE: (907) 561-5119 or 1-800-325-6532