Attach X-Rays Here

Central Laborers' Welfare Fund

P.O. BOX 1267
JACKSONVILLE, ILLINOIS 62651-1267
PHONE 217-243-8521
FAX 1-217-245-1293

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DENTAL SERVICE REPORT

☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ STATEMENT OF ACTUAL CHARGES

PART 1: INSURED INFORMATION

1. Patient Name: First | Middle Initial | Last
2. Relationship To Emp.: Self | Spse. | Dtr. | Son
3. Sex: M | F
4. Pt. Birth Date: Mo. | Day | Yr.
5. Employee Social Security Number
6. Employee/ Subscriber Name: First | Initial | Last
7. Mailing Address, Street, City, State, Zip Code
Tel. No. (   )
8. Is Patient Covered By Another Dental Plan? ☐ Yes ☐ No — If Yes, Policy Holder ID No.
9. Name and Address of Other Insurance Company

PATIENT'S AUTHORIZATION: I HEREBY ACCEPT THE FOLLOWING TREATMENT PLAN AND AUTHORIZE THE RELEASE OF ANY INFORMATION RELATIVE TO THIS CASE.

Signed (Patient, or Parent If Minor) | Date

To be completed and signed by the Member if direct payment by the Fund to the provider is desired. (This assignment may not be honored if signed by a dependent or person other than the insured Member.)

I hereby authorize the Central Laborers' Welfare Fund to pay directly to the provider all dental benefits for said expenses to which I am entitled under the terms of the Group Policy to the extent of their interest as established herein.

Date ____________ Signature of Member ____________

PART 2: DENTIST INFORMATION

10. Dentist Name
11. Mailing Address, Street, City, State, Zip Code
12. Dentist Soc. Sec. or T.I.N.
Tel. No. (   )
13. First visit Dt. Current Series
14. Place of Treatment: Office | Hosp | ECF | Other
15. Radiographs or Models Enclosed? (X-rays Should Be Mounted): No | Yes | How Many
16. Is Treatment Result of Occupational Illness or Injury? No | Yes | If Yes, Enter Brief Description And Dates
17. Is Treatment Result of Auto Accident? Other Accident? No | Yes | If Yes, Enter Brief Description And Dates
18. If Prosthesis, Is This Initial Placement? No | Yes | (If No, Reason For Replacement) | Date of Prior Placement

If yes, please provide the tooth numbers involved and the date of extractions of missing teeth.

19. Is Treatment For Orthodontics? No | Yes

DENTIST'S STATEMENT: I HEREBY CERTIFY THAT THE SERVICES LISTED HAVE BEEN OR WILL BE PROVIDED BY ME.

Dentist Signature | Lic. No. | Date

IDENTIFY MISSING TEETH WITH "X"

UPPER: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 — A B C D E | F G H I J

LOWER: 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17 — T S R Q P | O N M L K

PART 3: EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.

	TOOTH NUMBER 1	2	3	4	5	6	Surfaces	Description of Services, Including X-Rays, Prophylaxis, Materials Used, Etc.	Date Service Performed Mo.	Day	Yr.	Procedure Code	Fee For Each Service	No. of Times Performed	Elig. / Act.	Re-Proc. Code
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																

20. Remarks For Unusual Services

Examiner Number	21. Payee Code	Part. Status	COB	X-Ray	By-Pass Code	Dentist

CORRESPONDENCE

TOTAL FEE ON THIS FORM

22.	23.
24.	25.

(FRONT)

INSTRUCTIONS FOR INSURED:

Please be sure that you complete all information requested in Part 1, the Insured's Section on the front copy of this form. Particularly note:

Box 5 — Enter the insured's social security number.

Box 6 — Enter the insured's name.

Sign Patient Authorization Section.
If you want benefits to be paid directly to the provider please complete the Member Authorization Section.
Your dentist will complete the Dentist's Information and Treatment Section of this form.

If you have paid the dentist's fees, you are responsible for submitting this form, completed by you and the dentist, to:

Central Laborers' Welfare Fund's Dental Plan
P.O. Box 1267
Jacksonville, Illinois 62651-1267

You will be reimbursed as provided in your contract. Additional report forms may also be obtained from the same address or from your local union hall.

INSTRUCTIONS FOR THE DENTIST:

Mail original to: **Central Laborers' Welfare Fund's Dental Plan**
P.O. Box 1267
Jacksonville, Illinois 62651-1267

Payment will be made to the provider for those services that are covered under the insured's plan, subject to eligibility determination and any applicable co-insurance, deductible and/or other benefit limitation or exclusion provided that the Member Authorization Section is properly completed.

For your convenience, you can report up to six (6) individual teeth with the same service on one procedure line in addition to utilizing the elongated tooth map for specific procedure identification on the individual tooth such as extractions, restorations, bridges and partial dentures.

Tooth numbers, letters or tooth ranges should be entered to the left side of the treatment description section as follows:

Numbers:

	TOOTH NUMBER					
	1	2	3	4	5	6
1	Ø 1	Ø 2	2 2	2 3		

(To be used for Partial and Full Dentures)

Letters:

	TOOTH NUMBER					
	1	2	3	4	5	6
1	A	B	C			

Ranges:

	TOOTH NUMBER					
	1	2	3	4	5	6
1	Ø 1	X X	1 6	1 7	X X	3 2

***** ANY CLAIM FORM NOT PROPERLY COMPLETED WITH ALL PERTINENT INFORMATION WILL BE RETURNED FOR SUCH. *****