Dental Benefits Program

UFCW Health & Welfare Fund
of Northeastern Pennsylvania
3031B Walton Road
Plymouth Meeting, PA 19462
(610) 941-9400
Fax: (610) 941-9602

CLAIM NUMBER

CHECK ONE

☐ DENTIST'S PRE TREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

MEMBER COMPLETES

1. PATIENT NAME

2. RELATIONSHIP TO PARTICIPANT SELF 1 ☐ SPOUSE 2 ☐ DAUGHTER 3 ☐ SON 4 ☐ OTHER 5 ☐

3. SEX ☐ MALE ☐ FEMALE

4. PATIENT'S BIRTH DATE MO. | DAY | YEAR

5. IF FULL TIME STUDENT SCHOOL CITY

6. PARTICIPANT NAME FIRST MIDDLE LAST

7. PARTICIPANT SOCIAL SECURITY NUMBER

9. NAME OF EMPLOYER

8. PARTICIPANT MAILING ADDRESS

CITY STATE ZIP CODE

10. PATIENT MAILING ADDRESS

11. DO OTHER FAMILY MEMBERS HAVE DENTAL COVERAGE? YES ☐ NO ☐ EMPLOYEE NAME SOC. SEC. NO.

12. NAME AND ADDRESS OF EMPLOYER (IN ITEM 11)

13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES ☐ NO ☐

IF YES, GIVE PLAN NAME

UNION LOCAL

GROUP NO.

SPOUSE BIRTH DATE MO. | DAY

NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF AND INFORMATION RELATING TO THIS CLAIM.

X

SIGNED (PATIENT, OR PARENT IF MINOR) DATE SIGNED

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
23. IS TREATMENT RESULT OF AUTO INJURY?			
24. OTHER ACCIDENT?			
25. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			IF THE PROGRAM IS SECONDARY, ATTACH COPY OF PRIMARY CARRIER'S PAYMENT
26. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR PLACEMENT / 27. DATE OF PRIOR PLACEMENT
28. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCES PLACED / NO. OF TREATMENTS REMAINING

DENTIST COMPLETES

14. DENTIST'S NAME

15. MAILING ADDRESS

CITY STATE ZIP CODE

16. DENTIST'S SOC. SEC. NO (OR T.I.N.)

17. DENTIST S LIC .NO.

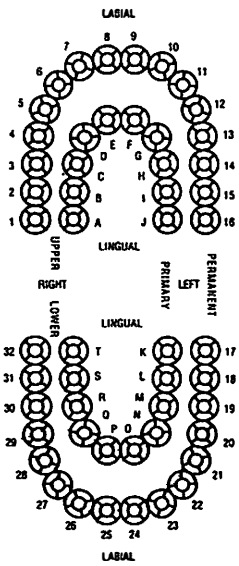
18. DENTIST'S PHONE N O

19. FIRST VISIT DATE CURRENT SERIES

20. PLACE OF TREATMENT OFFICE | HOSP. | ECF | OTHER

21. RADIOGRAPHS OR MODELS ENCLOSED NO | YES | HOW MANY?

DENOTE MISSING TEETH WITH "X"



30. REMARKS FOR UNUSUAL SERVICES

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

FOR OFFICE USE ONLY

	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.	DATE SERVICE PERFORMED MO. DAY YR.	PROCEDURE NUMBER	FEE	NO. OF TIMES PER-FORMED	ELIG. / ACT.	REPROC. CODE
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IF MORE LINES ARE NEEDED, PLEASE USE AN ADDITIONAL REPORT FORM (S) COMPLETING BOXES 1, 6, 8, AND 10 AT THE TOP OF THE FORM AND CHECK HERE ☐

TOTAL FEE CHARGED

NO. OF LINES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

X

SIGNED (DENTIST) DATE SIGNED

MY FEE ☐ HAS BEEN PAID ☐ HAS NOT BEEN PAID

FOR OFFICE USE ONLY		PARTIC. STATUS 2 3 4 6	COB	ELIG. BYP.	X-RAY	ODS BYP.	EXAM.	REMARKS
PAYEE CODE 1 2 3 4 5	CORRESPONDENCE CODE	GROUP NO.		AUTHORIZED SIGNATURE			ELIGIBILITY DATE	

Added to the website on January 14, 2025.

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