UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

DENTAL REFERRAL FORM

Patient's Name: _____ Company: _____

Participant's Name: _____ Local: _____

Participant's SS#: _____

Primary Care Dentist: _____

Dentist Referred To: _____

Type of Specialty Work: _____

Reason for Referral: _____

Date: _____

For current Eligibility status of participant, please contact the Fund office directly at 610-941-9400.