



CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

PO BOX 2280 • OAKLAND, CA 94621 • TELEPHONE (510) 633-0333 OR (888) 547-2054

ORTHODONTIC CLAIM FORM

PRE-AUTHORIZATION NOT REQUIRED

PLEASE PRINT OR TYPE

1. CARPENTER'S NAME			LAST	FIRST	MIDDLE	2. CARPENTER'S SOCIAL SECURITY NO.	
ADDRESS		NO.	STREET		CITY	STATE	ZIP CODE
3. PATIENT'S NAME					4. PATIENT'S BIRTHDATE		5. PATIENT'S RELATIONSHIP TO CARPENTER
					MO. DAY YEAR		(COVERAGE LIMITED TO DEPENDENT CHILDREN)
6. DENTIST'S NAME							7. DENTIST'S LICENSE NO.
8. DENTIST'S MAILING ADDRESS							9. DENTIST'S SOCIAL SECURITY NO. OR IRS TAXPAYER NO.
CITY, STATE, ZIP CODE							
10. IS PATIENT COVERED BY ANOTHER GROUP DENTAL PLAN?				YES	NO	11. IF YES, ENTER OTHER PLAN INFORMATION.	
						HOW SUSTAINED?	
12. IS TREATMENT RESULT OF ACCIDENT? IF YES, ENTER DATE OF INJURY.						IF YES, WHEN?	
13. HAS PATIENT HAD PRIOR ORTHODONTIC TREATMENT?							
14. ESTIMATED MONTHS OF TREATMENT							

<p>IDENTIFY MISSING TEETH WITH "X"</p> <p>Please Plot Plan</p> <p>REMARKS FOR UNUSUAL SERVICES</p>	PRELIMINARY WORK-UP INCLUDING X-RAYS, STUDY MODELS, ETC. ARE NOT A COVERED BENEFIT UNDER THE ORTHODONTIC PLAN				
	DESCRIPTION OF SERVICE		DATE OF SERVICE	PROCEDURE NUMBER	FEE
	<input type="checkbox"/> FULL TREATMENT CASE <input type="checkbox"/> ONE PHASE <input type="checkbox"/> TWO PHASE <input type="checkbox"/> OTHER		INITIAL PAYMENT: (BANDING DATE)		
	<input type="checkbox"/> LIMITED TREATMENT CASE TYPE OF MALOCCLUSION		MONTHLY:		
	STATE TYPE OF TREATMENT AND APPLIANCE:		OTHER:		
	LIMITED TO \$1,500.00 LIFETIME BENEFIT		TOTAL:		

<p>I hereby accept the foregoing treatment plan and authorize my dentist to release any and all medical information (including dental information) to the Carpenters Health and Welfare Trust Fund for California for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it.</p> <p>I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT authorize payment of dental benefits to the dentist.</p>		<p>The treatment listed above has been performed by me.</p>	
SIGNATURE OF CARPENTER OR SPOUSE		SIGNATURE OF DENTIST	
DATE		DATE	
		DENTIST'S TELEPHONE NO.	