SS #					

SUFFIX

CC EXAM 05

ATTENDING DENTIST'S STATEMENT

FORM NO. - DATE RELEASED

1. PATIENT NAME

2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER

3. SEX: M | F

4. PATIENT BIRTHDATE: MO | DAY | YEAR

5. IF FULL TIME STUDENT: SCHOOL CITY

6. EMPLOYEE NAME: FIRST NAME MIDDLE LAST

7. EMPLOYEE SOCIAL SECURITY NO.

8. EMPLOYEE MAILING ADDRESS

CITY STATE ZIP

NAME OF GROUP DENTAL PROGRAM

OPERATING ENGINEERS HEALTH & WELFARE TRUST
I.U.O.E. LOCAL 12
DENTAL BENEFITS PROGRAM
P.O. BOX 7066
PASADENA, CALIFORNIA 91109
PHONE: (626) 356-1004 - 1007

11. LOCATION (LOCAL)

12. ARE OTHER FAMILY MEMBERS EMPLOYED? YES ☐ NO ☐ EMPLOYEE NAME SOC. SEC. NO.

13. NAME AND ADDRESS OF EMPLOYER IN ITEM 12.

14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES ☐ NO ☐ DENTAL PLAN NAME UNION LOCAL GROUP NO. NAME AND ADDRESS OF CARRIER

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

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (INSURED PERSON) DATE

DENTIST'S INFORMATION

PLEASE PRESS FIRMLY

15. DENTIST NAME #

17. MAILING ADDRESS

CITY STATE ZIP

18. DENTIST SOC. SEC. OR T.I. NO. C

19. DENTIST LICENSE NO.

20. DENTIST PHONE NO.

21. FIRST VISIT DATE CURRENT SERIES

22. PLACE OF TREATMENT: OFFICE | HOSP. | ECS | OTHER

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

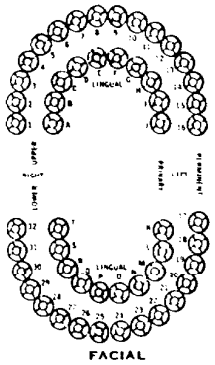
	YES	NO	
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT? 26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREAT. REMAINING

TO THE DENTIST: PREDETERMINATION OF BENEFITS REQUIRED FOR CLAIMS IN EXCESS OF $300.00.

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

IDENTIFY MISSING TEETH WITH "X"

FACIAL



FACIAL

32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHART SHOWN

DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO.	DAY	YR.	ADM. USE (TB)	FEE		PROCEDURE NUMBER	TOOTH # OR LETTER	SURFACE	ADMINISTRATIVE USE ALLOWED	REM	OR

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

SIGNED (DENTIST) DATE

TOTAL FEE CHARGED

MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

CARRIER USE ONLY

ELIGIBILITY VERIFIED BY

DATE

CLAIM NUMBER

ADS (75) Rev. 7/84

Form Approved by the Council on Dental Care Programs of the A.D.A. 1975