UFCW
LOCAL 655 WELFARE FUND
13537 Barrett Parkway Drive • Suite 100
Manchester, Missouri 63021
314-835-2700 or 1-866-565-2700

CHECK ONE:
☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF SERVICES

PATIENT

1. NAME

2. RELATION (check one): Self | Spouse | Child | Other (Explain)

3. SEX: M | F

4. BIRTHDAY: MONTH | DAY | YEAR

5. IF FULL TIME STUDENT:
School: _____
City: _____

EMPLOYEE

6. NAME

7. STREET

CITY/STATE/ZIP CODE

8. EMPLOYER (COMPANY)

9. YOUR SOCIAL SECURITY NUMBER

OTHER INSURANCE

10. OTHER FAMILY EMPLOYMENT ☐ Yes ☐ No
If "yes" please complete the following:
Name: _____ Relation: _____
Soc. Sec. No.: _____ Badge: _____
Employer Name: _____
Address: _____
City: _____

11. IS PATIENT COVERED BY OTHER INSURANCE? ☐ Yes ☐ No
If "yes" please complete the following:
Group Number: _____
Carrier Name: _____
Address: _____
City: _____

12. I HEREBY CERTIFY THAT THE STATEMENTS CONTAINED IN THIS FORM ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

13. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF PLAN BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY PLAN

EMPLOYEE SIGNATURE DATE

15. DENTIST NAME

16. MAILING ADDRESS

CITY, STATE, ZIP

17. DENTIST SOC. SEC. or T.I.N.

18. DENTIST LICENSE NO.

19. DENTIST PHONE NO.

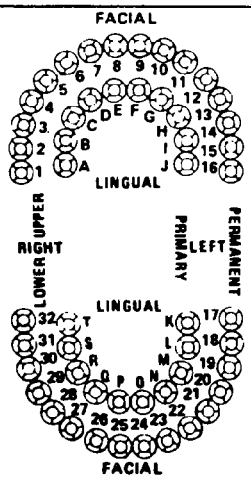
20. FIRST VISIT DATE CURRENT SERIES

21. PLACE OF TREATMENT: Office | Hosp. | ECF | Other

22. RADIOGRAPHS OR MODELS ENCLOSED? HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
23. Is Treatment Result Of Occupational Illness or Injury?			
24. Is Treatment Result Of Auto Accident?			
25. Other Accident?			
26. Are Any Services Covered by Another Plan?			
27. If Prothesis, Is This Initial Placement?			(If No, Reason for Replacement) — 28. DATE OF PRIOR PLACEMENT
29. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER — DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

STATEMENT OF SERVICE RENDERED
(Be sure to sign below)



INDICATE MISSING TEETH WITH AN 'X'

30. Examination and Treatment Plan — List in Order From Tooth No. 1 through Tooth No. 32. Use Charting System Shown

Tooth # or Letter	Surface	Description of Services (including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo.	Day	Yr.	ADA Procedure Number	Fee	For Fund Use Only
								TOTAL FEE CHARGED

The Treatment Listed Is Necessary In My Professional Judgement and I Request Authorization.

Signed (Dentist) Date

I Hereby Certify That the Services Listed Above Have Been Performed.

Signed (Dentist) Date

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UFCW

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

This claim form is also its own pre-addressed envelope for your convenience. After it has been completed, simply fold, stamp, and mail.