UNITED PLANT AND PRODUCTION WORKERS
WELFARE FUND

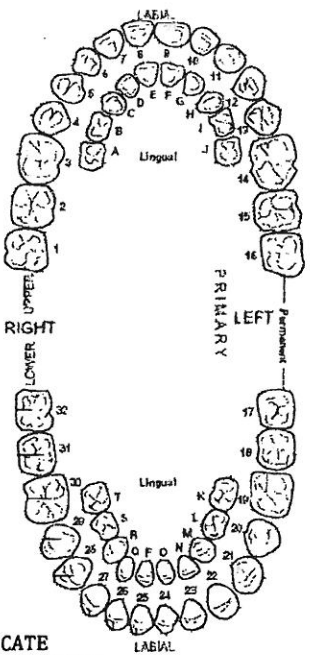
In Care of Dickinson Group
50 Charles Lindbergh Boulevard, Suite 207
Uniondale, NY 11553
Telephone: 516 833-9300
Fax: 516 740-5309

ALL CLAIMS ARE SUBJECT TO MEMBERS ELIGIBILITY AT THE TIME OF SERVICE

DENTAL CLAIM

FORM MUST BE COMPLETED BY MEMBER AND DENTIST, INCLUDING I.D. #

1..MEMBER NAME:	2. SOCIAL SECURITY NUMBER:
3..MEMBER MAILING ADDRESS:	4. PHONE #: / 5. UNION LOCAL #:
6. CITY: STATE: ZIP:	7. EMPLOYER NAME:
8. PATIENT NAME	9. PATIENT RELATIONSHIP TO MEMBER: / 10. PATIENT BIRTHDATE: MONTH DAY YEAR
11. DENTIST NAME:	12. FOR DEPENDENT CHILDREN AGE 19 OR OLDER IS PATIENT A FULL TIME STUDENT? ☐ NO ☐ YES
15. ID#:	14. IS PATIENT COVERED BY OTHER DENTAL PLAN?
16. PHONE #:	☐ NO ☐ YES IF YES, GIVE NAME OF THAT INSURANCE
17, IF PROSTHESIS, IS THIS INITIAL TREATMENT? NO YES IF NO, REASON FOR REPLACEMENT: / 18. DATE OF PRIOR PLACEMENT	CARRIER: POLICY NO.: STREET ADDRESS:
19. IS TREATMENT FOR OTHODONITICS? ☐ NO ☐ YES APPLIANCE INSERTED DATE:	CITY & STATE: OTHER EMPLOYER: EMPLOYER'S NAME:



INDICATE MISSING TEETH WITH AN "X"

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

* INDICATES OPTIONAL QUESTIONS

22. EXAMINATION AND TREATMENT RECORD – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

TOOTH OR LETTER	SURFACES	DESCRIPTION OF SERVICE (Including x-rays, prophylactics or materials used, etc.)	DATE SERVICE PERFORMED MO.	DAY	YR.	PROCEDURE NUMBER	FEE	DO NOT USE THIS COLUMN

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED.

DENTIST SIGNATURE: DATE:

TOTAL FEE ACTUAL CHGD.

AMT. P.D.

I HEREBY ACCEPT THE FOREGOING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

MEMBER'S SIGNATURE DATE:

I HEREBY AUTHORIZE PAYMENT FIRECTLY TO THE ABOVE-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES ABOVE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

MEMBER'S SIGNATURE: DATE:

This claim is not valid unless signed by member and returned to Fund Office within 30 days after first visit to dentist.