



**CENTRAL STATES
SOUTHEAST AND
SOUTHWEST AREAS
HEALTH AND WELFARE FUND**

**MAIL TO: Central States Southeast and Southwest Areas
Health and Welfare Fund
Claims Processing – Dental**

PO Box 5104 Des Plaines IL 60017-5104
1-800-323-5000

**DO NOT WRITE ABOVE THIS LINE.
FOR OFFICE USE ONLY.**

PART 1 – MEMBER

MEMBER'S SOC. SECURITY NUMBER		MEMBER'S FIRST NAME		MIDDLE INITIAL	LAST NAME		MEMBER'S BIRTH DATE			SEX	
							MONTH	DAY	YEAR	<input type="checkbox"/> M <input type="checkbox"/> F	
IF ADDRESS HAS CHANGED SINCE LAST CLAIM PLACE X IN THIS BOX.		MEMBER'S STREET ADDRESS			MEMBER'S CITY & STATE			ZIP CODE			
LOCAL UNION	EMPLOYER NAME				MEMBER'S MARITAL STATUS						
					<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed						
PATIENT'S NAME		RELATIONSHIP TO MEMBER				PATIENT'S BIRTHDATE			Is Patient covered by other Group Dental Plan?		
		<input type="checkbox"/> Self <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Other (explain) _____				MONTH DAY YEAR			<input type="checkbox"/> YES <input type="checkbox"/> NO		
THESE QUESTIONS MUST BE ANSWERED		FIRST NAME OF SPOUSE	Is your Spouse employed?	Does your Spouse have Group Dental coverage?	SPOUSE'S SOC. SEC. NUMBER			Spouse's Birthdate	MONTH	DAY	YEAR
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No							
SPOUSE'S EMPLOYER PROVIDING COVERAGE			ADDRESS OF SPOUSE'S EMPLOYER (STREET, CITY, STATE & ZIP CODE)								
SPOUSE'S INSURANCE COMPANY NAME & ADDRESS (STREET, CITY, STATE & ZIP CODE)						GROUP NUMBER			POLICY NUMBER		
AUTHORIZATION						ASSIGNMENT OF BENEFITS					
I hereby authorize release of any study models, x-rays and information relating to this claim.						I hereby certify that the dated services listed below have been rendered and I authorize benefit payment directly to the below-named orthodontist/dentist.					
_____			_____			_____			_____		
SIGNED (Patient, or Parent if Minor)			Date			SIGNED (Member)			Date		

PART 2 – ORTHODONTIST/DENTIST

Dentist Name (Indicate Specialty, if any)		Is treatment result of occupational illness or injury?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, enter a brief description and dates.	
Mailing Address		Is treatment result of auto accident or other accident?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
City, State, Zip		Are any services covered by another plan?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Dentist Tax I.D. No./or S.S. No. **		Dentist Lic. No.	Dentist Phone No.	If Prosthesis, is this initial placement?	<input type="checkbox"/> YES <input type="checkbox"/> NO
First visit date	Current Series	Place of Treatment Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other <input type="checkbox"/>	Radiographs or Models enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many?	Is treatment for Orthodontics? <input type="checkbox"/> YES <input type="checkbox"/> NO
				If NO, reason for re-placement.	Date of prior placement
				If service already commenced enter date appliances placed.	Mos. treatment remaining.

<input type="checkbox"/> PRE-DETERMINATION (ESTIMATE) <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES		CONTRACTUAL AGREEMENT BREAKDOWN																																																																												
DESCRIPTION OF SERVICE		INITIAL PAYMENT (BANDING FEE) \$ _____ MONTHLY PAYMENT \$ _____ TOTAL ORTHODONTIC FEE \$ _____ NO. OF MONTHS OF TREATMENT _____																																																																												
<input type="checkbox"/> FULL TREATMENT CASE <input type="checkbox"/> LIMITED TREATMENT CASE																																																																														
IF FULL TREATMENT CASE COMPLETE THE FOLLOWING: <input type="checkbox"/> ONE PHASE <input type="checkbox"/> TWO PHASE <input type="checkbox"/> OTHER (DESCRIBE) _____																																																																														
TYPE OF MALOCCLUSION: (CHECK BOXES WHICH BEST DESCRIBES THIS CASE) <input type="checkbox"/> CLASS I <input type="checkbox"/> CLASS II DIVISION I <input type="checkbox"/> CLASS II DIVISION II <input type="checkbox"/> CLASS III IF CLASS III, DO YOU ANTICIPATE SURGERY AT A LATER DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> QUESTIONABLE																																																																														
<input type="checkbox"/> CROSSBITE <input type="checkbox"/> DEEP OVERBITE <input type="checkbox"/> OPEN BITE <input type="checkbox"/> UPPER ARCH LENGTH DISCREPANCY <input type="checkbox"/> LOWER ARCH LENGTH DISCREPANCY SPACING $\frac{UR}{LR}$ _____ $\frac{UL}{LL}$																																																																														
TYPE OF APPLIANCE: <input type="checkbox"/> PHASE ONE <input type="checkbox"/> PHASE TWO <input type="checkbox"/> FIXED <input type="checkbox"/> REMOVABLE (SPECIFY) _____																																																																														
IF LIMITED TREATMENT CASE STATE TYPE OF TREATMENT: _____																																																																														
STARTING DATE OF TREATMENT: _____ INSERTION DATE OF ACTIVE APPLIANCE: _____																																																																														
		<table border="1"> <thead> <tr> <th></th> <th colspan="3">Date Service Performed</th> <th>FEE</th> </tr> <tr> <th></th> <th>Mo</th> <th>Day</th> <th>Year</th> <th></th> </tr> </thead> <tbody> <tr> <td>EXAMINATION</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>CASE DIAGNOSIS</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Insertion Active Appliance (Upper)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Insertion Active Appliance (Lower)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>OTHER (Describe):</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>MAINTENANCE/ADJUSTMENTS</td> <td></td> <td></td> <td></td> <td>*</td> </tr> <tr> <td>MAINTENANCE/ADJUSTMENTS</td> <td></td> <td></td> <td></td> <td>*</td> </tr> <tr> <td>MAINTENANCE/ADJUSTMENTS</td> <td></td> <td></td> <td></td> <td>*</td> </tr> <tr> <td>MAINTENANCE/ADJUSTMENTS</td> <td></td> <td></td> <td></td> <td>*</td> </tr> <tr> <td>MAINTENANCE/ADJUSTMENTS</td> <td></td> <td></td> <td></td> <td>*</td> </tr> <tr> <td>MAINTENANCE/ADJUSTMENTS</td> <td></td> <td></td> <td></td> <td>*</td> </tr> </tbody> </table>			Date Service Performed			FEE		Mo	Day	Year		EXAMINATION					CASE DIAGNOSIS					Insertion Active Appliance (Upper)					Insertion Active Appliance (Lower)					OTHER (Describe):															MAINTENANCE/ADJUSTMENTS				*	MAINTENANCE/ADJUSTMENTS				*	MAINTENANCE/ADJUSTMENTS				*	MAINTENANCE/ADJUSTMENTS				*	MAINTENANCE/ADJUSTMENTS				*	MAINTENANCE/ADJUSTMENTS				*
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		* IF CONTRACTUAL AGREEMENT BREAKDOWN HAS BEEN INDICATED, NO FEE ITEMIZATION IS REQUIRED.																																																																												

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<input type="checkbox"/> DIAG. <input type="checkbox"/> ORTHO. _____ <input type="checkbox"/> F.B. _____ <input type="checkbox"/> POST. <input type="checkbox"/> ALT. TR. _____	
Date _____	D. Consultant _____

PART 3 – ORTHODONTIST/DENTIST

I hereby certify that services listed above have been rendered to the named patient on the dates indicated.	
Signed Dentist _____	Date _____

** Dentist Tax I.D. Number or Social Security Number must be furnished under authority of Law when benefits are assigned