Ironworkers Health & Welfare Trust Fund of Western Canada

Funds Administrative Service Inc.
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DENTAL CARE STATEMENT

Policy #6115

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

PART 1 DENTIST

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT

CITY PROV POSTAL CODE

☐ CHECK HERE IF THIS IS A CHANGE OF ADDRESS

DENTIST

PHONE NO.

SPECIALIST YES ○ NO ○

IDENTIFICATION #

OFFICE VERIFICATION

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE MY PAYMENT DIRECTLY TO HM/HER.

SIGNATURE OF MEMBER

FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

I UNDERSTAN THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.

I ACKNOWLEDGE THAT THE TOTAL FEE OF $_____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.

I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DATE OF SERVICE			PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
MO	DY	YR						

FAILURE TO PROVIDE PROCEDURE CODES MAY RESULT IN DELAY OF PROCESSING THIS CLAIM.

TOTAL FEE SUBMITTED

INSTRUCTIONS

IF CHARGES WILL BE $_____ OR MORE, YOUR CLAIM SHOULD BE SUBMITTED FOR PRE-DETERMINATION OF BENEFITS.

X-RAYS OR STUDY MODELS MAY BE REQUIRED TO BE SUBMITTED FOR CROWNS OR BRIDGEWORK. X-RAYS WILL BE RETURNED PROMPTLY TO YOUR DENTIST.

PART 2 MEMBER (*Complete this part before taking the form to your dentist's office*)

1. PATIENT: RELATIONSHIP TO MEMBER_____ BIRTHDATE_____
   IF CHILD, INDICATE ☐ FULL TIME STUDENT ☐ HANDICAPPED
   IF FULL TIME STUDENT, SCHOOL ATTENDING:_____
   DATE ENROLLED_____ DATE COMPLETED_____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDRE ANY OTHER GROUP INSURANCE, GOV'T AGENCY OR DENTAL PLAN? ☐ NO ☐ YES – IF YES, ATTACH CO-INSURANCE STATEMENT.
   ☐ HEALTH ONLY ☐ DENTAL ONLY ☐ ORTHODONTIC ONLY ☐ OTHER_____
   IF COORDINATION OF BENEFITSNO LONGER APPLIES, TERMINATION DATE_____
   IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE SPOUSE'S DATE OF BIRTH_____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ NO ☐ YES
   GIVE DATE AND DETAILS_____
   _____

4. IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES
   IS ANY TREATMENT FOR TMJ PURPOSES? ☐ NO ☐ YES

5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ NO ☐ YES
   IF INITIAL PLACEMENT, ADVISE DATE TEETH WERE EXTRACTED_____
   AND ALL OTHER MISSING TEETH IN ARCH_____
   IF REPLACEMENT, GIVE DATE OR PRIOR PLACEMENT AND REASON FOR PLACEMENT
   _____
   _____

6. IS TREATMENT RESULT OF AN OCCUPATIONAL ILLNESS OR INJURY, OR OTHERWISE RELATED TO EMPLOYMENT? ☐ NO ☐ YES

7. MEMBER'S SOCIAL INSURANCE NO._____
   MEMBER'S BIRTHDATE ____/_____/_____
   MONTH DAY YEAR

8. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO THE INSURER/PLAN ADMINISTRATOR, ITS AUTHORIZED REPRESENATITIVE OR CONSULTANT FOR PURPOSES OF SETTLEMENT OF THIS CLAIM.

   MEMBER'S NAME_____
   (PLEASE PRINT)
   ADDRESS: _____
   _____
   TELEPHONE NUMBER_____
   DATE:_____/_____/_____
   MONTH DAY YEAR

   _____
   SIGNATURE OF MEMBER

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL