Jefferson Federation of Teachers
HEALTH AND WELFARE FUND

MAILING ADDRESS: P.O. BOX 6137, METAIRIE, LOUISIANA 70009-6137
(504) 455-7261

DENTAL CARE BENEFITS STATEMENT

FORWARD COMPLETED CLAIM TO FUND OFFICE — **DO NOT COMPLETE SHADED AREAS**

PART A - TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME (LAST, FIRST, MIDDLE)	2. RELATIONSHIP TO EMPLOYEE: Self / Spouse / Child / Other	3. SEX: M / F	4. PATIENT BIRTHDATE: MO. / DAY / YEAR	5. IF FULL-TIME STUDENT NAME OF SCHOOL / CITY

6. EMPLOYEE NAME (LAST, FIRST, MIDDLE)	7. EMPLOYEE SOCIAL SECURITY NO.	8. EMPLOYEE DATE OF BIRTH: MONTH / DAY / YEAR

9. EMPLOYEE MAILING ADDRESS/IS THIS AN ADDRESS CHANGE SINCE YOUR LAST DENTAL CLAIM? ☐ YES ☐ NO	10. EMPLOYEE HOME PHONE NUMBER
CITY, STATE, ZIP	

11. IS CLAIM DUE TO AN ACCIDENT? ☐ YES ☐ NO	12. DID ACCIDENT OCCUR AT WORK? ☐ YES ☐ NO

13. IS SPOUSE EMPLOYED? ☐ YES ☐ NO — SOC. SEC. NO. — IF YES, INDICATE NAME	14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO — IF YES, SPOUSE'S DATE OF BIRTH: MONTH / DAY / YEAR	NAME AND ADDRESS OF CARRIER	GROUP NO.

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 DENTAL PLAN BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED EMPLOYEE _____ DATE _____

PART B - TO BE COMPLETED BY DENTIST

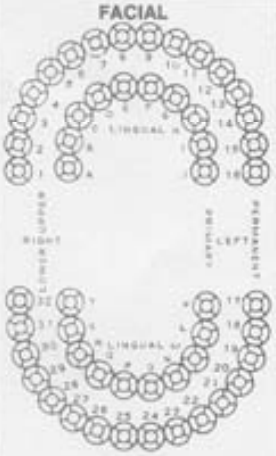
1. DENTIST'S FULL NAME AND ADDRESS	2. DENTIST SOC. SEC. OR T.I.N.	3. DENTIST LICENSE NO.	4. DENTIST PHONE NO.

	5. FIRST VISIT DATE CURRENT SERIES	6. PLACE OF TREATMENT: OFFICE / HOSP. / ECF / OTHER	7. RADIOGRAPHS OR MODELS ENCLOSED	NO	YES	HOW MANY?

8. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES	12. IF PROTHESIS OR CROWN(S). IS THIS INITIAL PLACEMENT?	NO	YES	(IF NO, REASON FOR REPLACEMENT)	13. DATE OF PRIOR PLACEMENT
9. IS TREATMENT RESULT OF AUTO ACCIDENT?				14. IS TREATMENT FOR ORTHODONTICS?			TOTAL FEE	DATE APPLIANCES PLACED
10. OTHER ACCIDENT?								
11. ARE ANY SERVICES COVERED BY ANOTHER PLAN?							TOTAL MONTHS IN ORIGINAL TREATMENT PLAN	

CHECK ONE:
- ☐ Pre-treatment Estimate
- ☐ Statement of Actual Services

FACIAL



FACIAL

Indicate Missing Teeth With X and Dates Extracted.

Unusual Services-Use Remarks

15. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN

Tooth No. or Letter	Surface	DESCRIPTION OF SERVICE (Including X-rays, Prophylaxis, materials used, etc.) LINE NO.	Date service performed Mo. Day Year	ADA Procedure No.	Fee

Remarks

TOTAL FEE $

I HEREBY CERTIFY THAT SERVICE(S) LISTED ABOVE HAVE BEEN PERFORMED ON THE NAMED PATIENT ON THE DATE(S) INDICATED AND THAT THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO MY PATIENTS.

DENTIST'S SIGNATURE _____ DATE _____

EMPLOYEE INSTRUCTIONS
HOW TO FILE A CLAIM FOR DENTAL BENEFITS

THE CLAIM FORM SHOULD BE COMPLETED AS FOLLOWS:

.... Complete Part A, Patient Information, in its entirety. If an item is left blank, a request for such information will be generated from the Company or the Fund Office. In order to avoid any unnecessary delays, make sure all items are completed.

.... Ask the dentist how much the charge will be.

IF LESS THAN $200, OR FOR EMERGENCY TREATMENT

.... Your dentist completes Part B of the form indicating the work completed.

.... Payment in the amount provided by the Plan will be sent to you or your dentist depending on your election in Part A of the form.

IF $200 OR MORE — BENEFITS MAY BE PRE-DETERMINED

One advantage of your Plan is that you can find out how much will be paid by the Plan before you have the dentist complete work. This procedure is called a "Pre-Treatment Estimate". While a pre-treatment estimate is not required, it is to your advantage to know your benefits before you agree to have extensive work done.

.... Your dentist completes Part B of the form indicating the work to be performed and the cost.

.... A Pre-Treatment Estimate form will be sent to you and your dentist so that you and your dentist may review the services to be performed and the benefits available.

.... The dentist will return the Pre-Treatment Estimate form to the Fund Office as the work is completed.

.... Payment in the amount provided by the Plan will be sent to you or your dentist depending on your election in Part A of the form.