CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

PO BOX 2280 • OAKLAND, CA 94621 • TELEPHONE (510) 633-0333 OR (888) 547-2054

ORTHODONTIC CLAIM FORM

PRE-AUTHORIZATION NOT REQUIRED

PLEASE PRINT OR TYPE

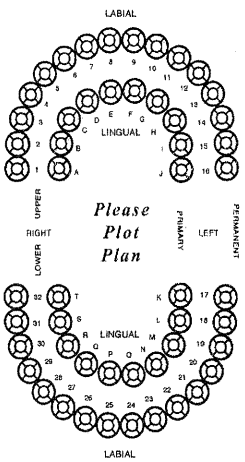
1. CARPENTER'S NAME LAST	FIRST	MIDDLE	2. CARPENTER'S SOCIAL SECURITY NO.
			___ ___ ___ ___ ___ ___ ___ ___ ___
ADDRESS NO. STREET	CITY	STATE	ZIP CODE

3. PATIENT'S NAME	4. PATIENT'S BIRTHDATE MO. DAY YEAR	5. PATIENT'S RELATIONSHIP TO CARPENTER (COVERAGE LIMITED TO DEPENDENT CHILDREN)

6. DENTIST'S NAME	7. DENTIST'S LICENSE NO.
8. DENTIST'S MAILING ADDRESS	9. DENTIST'S SOCIAL SECURITY NO. OR IRS TAXPAYER NO.
CITY, STATE, ZIP CODE	

	YES	NO	
10. IS PATIENT COVERED BY ANOTHER GROUP DENTAL PLAN?			11. IF YES, ENTER OTHER PLAN INFORMATION.
12. IS TREATMENT RESULT OF ACCIDENT? IF YES, ENTER DATE OF INJURY.			HOW SUSTAINED?
13. HAS PATIENT HAD PRIOR ORTHODONTIC TREATMENT?			IF YES, WHEN?
14. ESTIMATED MONTHS OF TREATMENT			

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

PRELIMINARY WORK-UP INCLUDING X-RAYS, STUDY MODELS, ETC. ARE NOT A COVERED BENEFIT UNDER THE ORTHODONTIC PLAN

DESCRIPTION OF SERVICE	DATE OF SERVICE	PROCEDURE NUMBER	FEE
INITIAL PAYMENT: (BANDING DATE)			
☐ FULL TREATMENT CASE			
☐ ONE PHASE ☐ TWO PHASE ☐ OTHER — **MONTHLY:**			
☐ LIMITED TREATMENT CASE — **OTHER:**			
TYPE OF MALOCCLUSION — **TOTAL:**			

STATE TYPE OF TREATMENT AND APPLIANCE:

LIMITED TO $1,500.00 LIFETIME BENEFIT

I hereby accept the foregoing treatment plan and authorize my dentist to release any and all medical information (including dental information) to the Carpenters Health and Welfare Trust Fund for California for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it.

I ☐ **DO** ☐ **DO NOT** authorize payment of dental benefits to the dentist.

SIGNATURE OF CARPENTER OR SPOUSE DATE

The treatment listed above has been performed by me.

SIGNATURE OF DENTIST DATE

DENTIST'S TELEPHONE NO.