IUPAT LOCAL 177 WELFARE TRUST FUND

DENTAL CARE CLAIM FORM

☐ Duplicate Form ☐ Predetermination

1. DENTAL SERVICE PROVIDER

PATIENT

NAME (LAST, FIRST)

ADDRESS

CITY | PROVINCE | POSTAL CODE

PROVIDER

UNIQUE NO. | SPECIALTY | PATIENT'S OFFICE ACC'T NO.

NAME/ADDRESS

TELEPHONE NUMBER

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

_____

SIGNATURE OF MEMBER

FOR DENTIST USE ONLY – For additional information, diagnosis, procedure or special consideration.

Was this emergency treatment? ☐ No ☐ Yes – If yes, please provide additional details

I understand 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 the Administrator.

_____

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION:

If charges will be $300.00 or more, your claim should be submitted for predetermination of benefits.

DATE OF SERVICE (MONTH/DAY/YEAR)	PROCEDURE CODE	TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
Failure to provide procedure codes may result in delay of processing this claim.					**TOTAL FEE SUBMITTED**	

2. PATIENT INFORMATION

Complete this section before taking the form to your dentist's office

1. Patient: Relationship to Member:_____ Date of Birth: _____
   If Child, please indicate ☐ Full-Time Student ☐ Disabled
   If student, indicate school attending:_____
   Date enrolled:_____ Date Completed:_____
2. Are any dental benefits or services provided under any other group insurance, government agency, W.C.B. or dental plan? ☐ No ☐ Yes – If yes, attach co-insurance statement.
   If this claim is for a child, please indicate spouse's date of birth:_____
3. Is the treatment result of an accident, occupational illness or injury, or otherwise related to employment?
   ☐ No ☐ Yes – If yes give details separately.
4. If denture, crown or bridge, is this the initial placement? ☐ Yes ☐ No
   If initial placement, advise date teeth were extracted_____
   List all other missing teeth in arch_____
   If replacement, give date of prior placement and reason for replacement._____
5. Is any treatment required for orthodontic purposes? ☐ Yes ☐ No
   Is any treatment from TMJ purposes? ☐ Yes ☐ No

3. MEMBER INFORMATION

GROUP NUMBER	PLAN NAME	CARRIER	CARRIER ID
5801	IUPAT LOCAL 177 WELFARE TRUST FUND	FAS	610614

NAME (LAST, FIRST)		YOUR CERT. NO. OR I.D. NO.	DATE OF BIRTH
ADDRESS	PROVINCE	POSTAL CODE	PHONE NUMBER

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Funds Administrative Service Inc. to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand 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 the supplier for the entire amount.

SIGNATURE OF MEMBER DATE

Please return to:
Funds Administrative Service Inc.
10154 – 108 Street, NW, Edmonton AB, T5J 1L3
Phone (780) 452-5161 Toll free: 1-800-770-2998 Fax (780) 452-5388