UFCW
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WELFARE FUNDS
of LOCAL 464A
DENTAL CLAIM FORM

SUBMIT TO
LOCAL 464A WELFARE FUND
245 PATERSON AVENUE
LITTLE FALLS, N.J. 07424

CLAIMS MUST BE FILED WITHIN 90 DAYS AFTER COMPLETION OF TREATMENT

PART A — TO BE COMPLETED BY MEMBER — AVOID DELAY; ANSWER ALL QUESTIONS.

MEMBER'S NAME — PLEASE PRINT	SOCIAL SECURITY NUMBER	HOME PHONE NO.
ADDRESS / CITY / STATE / ZIP		
EMPLOYER	STORE #	EMPLOYER'S ADDRESS
PATIENT NAME (IF A DEPENDENT)	RELATIONSHIP TO MEMBER: SELF / SPOUSE / CHILD / OTHER	PATIENT BIRTHDATE: MO / DAY / YEAR
IF FULL TIME STUDENT: SCHOOL / CITY		
IS PATIENT COVERED BY ANOTHER DENTAL PLAN? / DENTAL PLAN NAME / UNION LOCAL / GROUP NO. / NAME AND ADDRESS OF CARRIER		

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP REIMBURSEMENT PLAN BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (COVERED MEMBER) _____ DATE _____

I HEREBY CERTIFY THE STATEMENTS HEREON AND ATTACHED ARE COMPLETE, AND I AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE OR ORGANIZATION IN POSSESSION OF INSURANCE OR OTHER BENEFIT INFORMATION CONCERNING ME OR MY DEPENDENTS TO FURNISH AND DISCLOSE ALL KNOWN FACTS, INCLUDING CLINICAL REPORTS, CHARTS, AND X-RAYS, CONCERNING THIS CLAIM. A COPY OR PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

SIGNATURE (PATIENT OR PARENT) _____ DATE _____

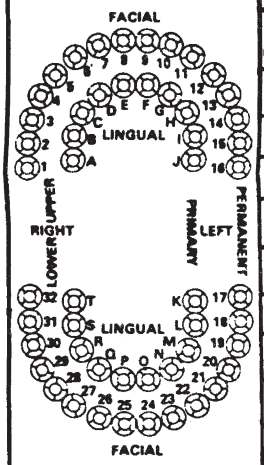
PREAUTHORIZATION REQUIRED:

IF TOTAL CHARGES EXCEED $200.00 FOLLOW INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM

PART B — TO BE COMPLETED BY ATTENDING DENTIST — AVOID DELAY; ANSWER ALL QUESTIONS.

DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT? / OTHER ACCIDENT?			
CITY, STATE, ZIP	ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SOC. SEC. OR T.I.N. / DENTIST LICENSE NO. / DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO REASON FOR REPLACEMENT) / DATE OF PRIOR PLACEMENT
FIRST VISIT DATE CURRENT SERIES / PLACE OF TREATMENT: OFFICE / HOSP. / ECF / OTHER	X-RAYS OR MODELS ENCLOSED? NO / YES / HOW MANY?			IS TREATMENT FOR ORTHODONTICS?

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT RECORD — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) If services listed exceed 14 line items please complete separate form.	DATE SERVICE PERFORMED MO.	DAY	YEAR	ADA PROCEDURE NUMBER	FEE		FOR UNION USE ONLY

PREAUTHORIZATION OF TREATMENT PLAN

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST PREAUTHORIZATION IN ACCORDANCE WITH PLAN RULES.

DENTIST SIGNATURE _____ DATE _____

TREATMENT COMPLETED - PAYMENT REQUESTED

THE TREATMENT LISTED WAS COMPLETED BY ME AND WAS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST PAYMENT IN ACCORDANCE WITH PLAN RULES.

DENTIST SIGNATURE _____ DATE _____

TOTAL FEE CHARGED		
PLAN PAYS		

AUTHORIZED PREDETERMINATION FORMS WILL ONLY BE HELD ON FILE FOR SIX MONTHS.

FORM NO. 1

PROCEDURES TO BE OBSERVED WHEN UTILIZING OUTSIDE DENTISTS AS ESTABLISHED BY TRUSTEES

1. If you visit an outside dentist, and the projected cost of his services has been established as more than $200, you must mail a Local 464A Preauthorization Dental Claim completed by you and the outside dentist, to the Welfare Department of Local 464A, 245 Paterson Avenue, Little Falls, New Jersey 07424 prior to any work being commenced. Failure to submit a Preauthorization Dental Claim shall result in a denial of reimbursement. The need for preauthorization is based on the dentist fees at usual and customary charges. Preauthorization is required regardless of the reduction of the dentist fees either by discounts, or the presence of or payment from any other insurance coverage.

2. Upon the receipt of the Preauthorization Dental Claim form, an appointment will be established with our closest Dental Center at your convenience by our contacting you to permit an examination and review of the Claim.

3. After you have been examined at one of our Dental Centers and receive written approval for the work to be completed, then, and only then, may you commence treatment with your outside dentist. (Approval will be provided in writing to the dentist. You will also receive a copy.)

4. After the outside dentist has completed the work previously approved by our Dental Center, a Local 464A Dental Claim form must be mailed to this office by the outside dentist indicating the exact nature of the work actually completed.

5. In the event that no questions arise concerning the nature of the dental work performed, a check will be mailed according to the reimbursement under the dental fee schedule.

6. In the event the outside dentist has deviated from the work to be performed, or a question arises concerning the nature of the dental procedures performed by the outside dentist, you will be called back to one of the Dental Centers for re-examination.

7. This preauthorization procedure does not apply to oral examination, cleanings, fluoride applications, dental X-rays, or a dental treatment program of $200 or less completed in any 12-month period.

8. Under no circumstances will any reimbursement be made to you or your outside dentist if the procedures outlined herein are not strictly followed.