ATTENDING DENTIST'S STATEMENT

DENTAL CLAIM UNIFORM REPORT FORM

RETURN THIS FORM TO:

NORTHERN NEVADA LABORERS HEALTH & WELFARE TRUST FUND

445 Apple St. P.O. Box 11337 Reno, Nevada 89510 (775) 826-7200

EMPLOYEE MUST COMPLETE THIS SECTION

EMPLOYEE'S NAME	SOCIAL SECURITY NUMBER	NAME OF EMPLOYER (Company Name)
EMPLOYEE'S MAILING ADDRESS	DATE HIRED month day year	YOUR LOCAL UNION NO. / ADM. USE ONLY
CITY-STATE-ZIP CODE	If your Address has changed in the past six months, Please check box ☐	IF PATIENT IS A DEPENDENT WHO IS EMPLOYED, SHOW NAME OF DEPENDENT'S EMPLOYER
PATIENT'S NAME – *Show Address if Different than Employee*	PATIENT'S RELATIONSHIP TO EMPLOYEE / PATIENT'S BIRTH DATE month day year	DATE OF PATIENT'S FIRST VISIT Current Series

DENTIST'S	
	LICENSE NUMBER
	PHONE NUMBER
	S.S. NO. OR IRS NO.

NAME .....

ADDRESS .....

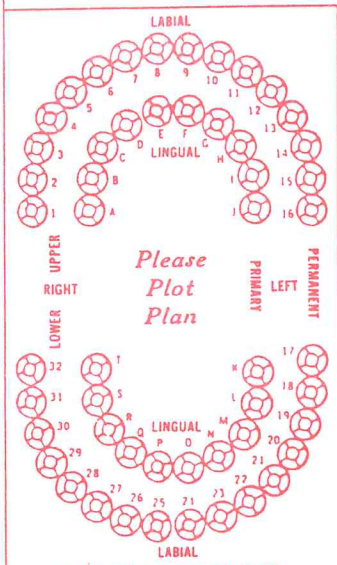
PATIENT COVERED BY ANOTHER PLAN? YES ☐ NO ☐ IF YES, COMPLETE BELOW

PLAN NAME	GROUP NO.
ADDRESS	NAME OF PERSON COVERED UNDER OTHER PLAN
CITY/STATE/ZIP CODE	SOCIAL SECURITY NO.
EMPLOYER	PRIMARY PERSON'S DATE OF BIRTH

DATE OF PRIOR PLACEMENT

IF PROSTHESIS, IS THIS INITIAL PLACEMENT? YES ☐ NO ☐ (if "no," reason for replacement)

	YES	NO		YES	NO
Is any of the treatment for orthodontic purposes?	☐	☐	Result of occupational injury?	☐	☐
Treatment result of accident?	☐	☐	Is this claim a re-billing or re-submission?	☐	☐
Are X-rays enclosed?	☐	☐	If yes, how many ____		



INDICATE MISSING TEETH WITH AN "X"

EXAMINATION AND TREATMENT RECORD – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICES (including x-rays, prophylaxis, materials used, etc.)	DATE SERVICE PERFORMED mo.	day	yr.	PROCEDURE NUMBER	FEE		ADMINISTRATIVE USE ONLY

Total Fee		
Patient Paid		
Balance Due		

FOR PAYMENT– PLAN MEMBER AND DEPENDENTS MUST BE ELIGIBLE AT TIME SERVICES ARE RENDERED

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE DATE(S) SHOWN ABOVE.

DENTIST'S SIGNATURE _____ DATE _____

I AUTHORIZE ANY MEDICAL INFORMATION RELATING TO THIS CLAIM TO BE DISCLOSED TO AND ACQUIRED BY THE ADMINISTRATOR OF THIS PLAN AND SUCH AGENTS OF THE ADMINISTRATOR AS ARE NECESSARY TO PROCESS THIS CLAIM. SUCH INFORMATION MAY BE DISCLOSED BY A HEALTH CARE PROVIDER OR OTHER PLAN ADMINISTRATOR, AND WILL BE USED FOR THE PURPOSE OF PROCESSING THIS CLAIM. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL THE CLAIM IS PAID, PROVIDED, SUCH INFORMATION SHALL BE RETAINED BY THE ADMINISTRATOR IF REQUIRED BY LAW.

PATIENT'S SIGNATURE _____ DATE _____

Parent or Guardian's Signature if Patient is a minor

UPON REQUEST, THE PATIENT SHALL BE FURNISHED WITH A COPY OF THIS AUTHORIZATION.

I hereby certify that the foregoing statements including any accompanying statements are to the best of my knowledge and belief true and correct. CHECK: ✓ I DO ☐ DO NOT ☐ authorize the administrator, in his sole discretion, to pay directly to the named dentist or any other supplier of services, any benefits otherwise payable to me, but not to exceed any of the charges by the dentist or other supplier of services. I understand that I am financially responsible for any charges not covered by this authorization.

EMPLOYEE'S SIGNATURE _____ DATE _____