U F C W Tri-State Health and Welfare Fund
27 Roland Ave., Suite 100,
Mt. Laurel, N.J. 08054-1056
(856) 793-2500 (800) 228-7484

ORTHODONTIC AUTHORIZATION FORM

►► PART A: PARTICIPANT / MEMBER - READ REVERSE SIDE FOR INSTRUCTIONS

Participant's name - First Middle Last		Home phone ( ) Area Code Number
Address	City, State, Zip	
Social Security Number	Employer	Union Local Number
Patient Name	Relationship to Member	Date of Birth
Is Patient Covered by another Dental Plan? If YES, give: Plan Name,	Group #	Insured's Name and SS#
Is treatment needed as the result of an injury or auto accident? If so state how, when, and where injured.		

►► PART B: DENTIST - READ REVERSE SIDE FOR INSTRUCTIONS - TREATMENT MUST BE PRE-AUTHORIZED

Dentist - First Middle Last		
Address	City, State, Zip	
Dentist's SS Number or FEIN Number	Dentist's License Number	Dentist's Phone - (Area Code) Number

►► PART C: TREATMENT PLAN AND DIAGNOSIS

Patient's Full Name Date of Birth

Request for: G **Pre-treatment Estimate** G **Statement of Actual Services**

Is treatment result of occupational illness or injury? YES □ NO □ or auto accident or injury? YES □ NO □
If yes to either question, give date & brief description

PLEASE ESTIMATE NUMBER OF MONTHS FOR THIS TREATMENT -

DIAGNOSIS	CDT-2 CODE	DESCRIPTION OF SERVICE	Date of Service	DOCTOR'S CHARGE	*FUND USE*
		TOTAL FEE CHARGED			

►► PART D: SIGNATURES

PARTICIPANT

I hereby agree with the treatment plan, authorize release of any information relating to this claim, and assign benefits be paid to the dentist. I understand I am financially responsible to the provider for any co-payments or services not covered by the plan. I also understand that should I become ineligible, I will be financially responsible*.

Signature T Date

ORTHODONTIST

I hereby certify that the treatment listed is necessary in my professional judgment and the services were performed, as listed above, by a duly licensed dentist.

Signature T Date

HOW TO FILE A CLAIM FOR ORTHODONTIC BENEFITS

PART A
To assure proper identification, Part A should be completed by the participant before taking the form to the dentist.

PART B & C
THE DENTIST MUST COMPLETE PART B & PART C AND SUBMIT THIS FORM REQUESTING **PRE-TREATMENT AUTHORIZATION** TO THE FUND OFFICE.

a) The dentist will check the appropriate box in Part C, complete patient information including treatment plan, diagnosis, description of services, x-rays and amount charged to the UFCW Health and Welfare Fund Office.
b) The UFCW Tri-State Health and Welfare Office will send an explanation of benefits to the participant and the dentist.

PART D
AFTER ORTHO BANDING HAS BEEN COMPLETED:

a) the participant signs the left hand side of Part D at the bottom of the claim form, certifying treatment plan, release of information, acknowledgment of financial responsibility, and assignment of benefits.
b) the dentist signs the right hand side of Part D at the bottom of the claims form, certifying services were performed.
c) the form is submitted for payment to:
   UFCW Tri-State Health and Welfare Fund
   27 Roland Avenue, Suite 100
   Mt. Laurel, NJ 08054-1056
d) any questions, please call 800-228-7484 or 856-793-2500