

Dental Claim Form

CWA Local 1180



1. <input type="checkbox"/> Dentist's pretreatment estimate <input type="checkbox"/> Dentist's statement of actual services Specialty (see backside)	3. Carrier Name CWA Local 1180 Scheduled Dental Benefit Plan	
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT Prior Authorization #	4. Carrier Address 253 West 35th Street, 12th Floor	
5. City New York	6. State NY	

PATIENT	8. Patient Name (Last, First, Middle)	9. Address	10. City	11. State
	12. Date of Birth (MM/DD/YYYY) / /	13. Patient ID #	14. Gender <input type="checkbox"/> M <input type="checkbox"/> F	15. Phone Number ()
	17. Relationship to Subscriber/Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		18. Employer/School Name Address	

SUBSCRIBER / EMPLOYEE	19. Subs./Emp. ID#/SSN#	20. Employer Name	21. Group #	OTHER POLICIES	31. Is patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical	32. Policy #	
	22. Subscriber/Employee Name (Last, First, Middle)				33. Other Subscriber's Name		
	23. Address				24. Phone Number ()	34. Date of Birth (MM/DD/YYYY) / /	35. Gender <input type="checkbox"/> M <input type="checkbox"/> F
	25. City		26. State		27. Zip Code	36. Plan/Program Name	
	28. Date of Birth (MM/DD/YYYY) / /		29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		37. Employer/School Name Address		
	30. Gender <input type="checkbox"/> M <input type="checkbox"/> F				38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student		

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X _____ Date (MM/DD/YYYY)
Signed (Patient/Guardian)

X _____ Date (MM/DD/YYYY)
Signed (Employee/Subscriber)

BILLING DENTIST	42. Name of Billing Dentist or Dental Entity	43. Phone Number ()	44. Provider ID #	45. Dentist Soc. Sec. or T.I.N.
	46. Address	47. Dental License #	48. First visit date of current series:	49. Places of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other
	50. City	51. State	52. Zip Code	53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? <input type="checkbox"/> No
	55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No			54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
	56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates _____		57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither Brief description and dates _____	

58. Diagnosis Code Index (optional)
 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order												Admin. Use Only														
Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee																			
60. Identify all missing teeth with "X"																										
Permanent								Primary				Total Fee														
1	2	3	4	5	6	7	8	9	10	11		12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	Max. Allowable
61. Remarks for unusual services																										

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.	63. Address where treatment was performed		
X _____ Signed (Treating Dentist)	License # _____	Date (MM/DD/YYYY) _____	64. City
			65. State
			66. Zip Code