ATTENDING DENTIST'S STATEMENT

MAIL ORIGINAL TO: ➤

Michigan Conference of Teamsters Welfare Fund
2700 Trumbull
Detroit, MI 48216

PLEASE TYPE ALL REQUIRED INFORMATION
SEE REVERSE FOR INSTRUCTIONS

DENTIST'S STATEMENT OF ACTUAL SERVICES ☐ | DENTIST'S PRE-DETERMINATION REQUEST. ☐

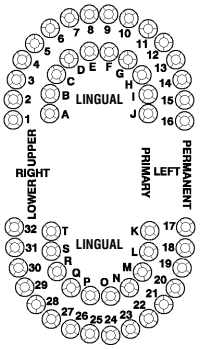
PATIENT & SUBSCRIBER INFORMATION

1. PATIENT NAME FIRST LAST MIDDLE INITIAL
2. PATIENT RELATIONSHIP TO SUBSCRIBER SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
3. PATIENT SEX MALE ☐ FEMALE ☐
4. PATIENT BIRTHDATE MM DD CC/YY
5. SUBSCRIBER NUMBER
6. SUBSCRIBER BIRTHDATE MM DD CC/YY
7. GROUP NUMBER
8. IF PATIENT IS A DEPENDENT OVER 19, PLEASE INDICATE STATUS
☐ FULL TIME STUDENT ☐ TOTALLY & PERM DISABLED ☐ IRS DEPENDENT ☐ SPONSORED DEPENDENT
9. SUBSCRIBER NAME FIRST LAST MIDDLE INITIAL
8a. ☐ ONLY FOR STATES ALLOWING ASSIGNMENT (SEE REVERSE): I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE GROUP DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE BELOW NAMED DENTIST, AND SIGN ON LINE 11
10. SUBSCRIBER MAILING ADDRESS
11. SUBSCRIBER SIGNATURE DATE
12. CITY STATE ZIP CODE
13. EMPLOYER/COMPANY NAME

IF PATIENT IS COVERED BY ANOTHER PLAN, COMPLETE ITEMS 14-24

14. SUBSCRIBER NAME FIRST LAST MIDDLE INITIAL
15. OTHER SUBSCRIBER NUMBER
16. BIRTHDATE MM DD CC/YY
17. GROUP NUMBER
18. AMOUNT OF PRIMARY PAYMENT $
19. MAILING ADDRESS
22. NAME OF OTHER CARRIER
20. CITY STATE ZIP CODE
23. CARRIER ADDRESS
21. NAME OF EMPLOYER
24. CITY STATE ZIP CODE

IDENTIFY MISSING TEETH WITH "X"



PROVIDER INFORMATION

25. PROVIDER BUSINESS NAME
26. PROVIDER TAX IDENTIFICATION NUMBER
27. SERVICE OFFICE ADDRESS (NUMBER/STREET)
28. DDS LIC. NO.
29. STATE
30. SPEC. CD.
31. CITY STATE ZIP CODE
32. DENTIST PHONE NO.

33. No ☐ Yes ☐ — IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS INJURY?
34. No ☐ Yes ☐ HOW MANY? ☐ — RADIOGRAPHS OR MODELS ENCLOSED?
35a. No ☐ Yes ☐ — IS TREATMENT RELATED TO ORTHODONTICS?
35b. MM DD CC/YY — IF SERVICE ALREADY COMMENCED, DATE APPLIANCES PLACED
35c. NUMBER ☐ — OF ACTIVE MONTHS OF TREATMENT

Important: Please make sure the information you enter in the form is complete and accurate.

TOOTH NUMBER OR LETTER	SURFACE	DATE SERVICE PERFORMED MM/DD/YY	PROCEDURE NUMBER	FEE $ Dollars.Cents

DO NOT TYPE IN SHADED AREA

REMARKS

I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO PREDETERMINE THE PROCEDURES WHICH ARE NOT DATED AND THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGEMENT.

SIGNED (DENTIST) | DATE

$
TOTAL FEE CHARGED

Revised 05/25

Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, MI 48216
(313) 964-2400

INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

Please use this claim form for Michigan Conference of Teamsters Welfare Fund subscribers.

In cases where there is another carrier involved, complete the coordination of benefits section, boxes 14-24. If not, leave these boxes empty. Don't use zeros, lines, or N/A for not applicable. Box 118, amount of primary payment, should be filled in only when you know how much the primary carrier paid. Do not put $0 unless the primary carrier's actual payment determination was $0.

The remarks section should be used only for information pertaining to the treatment rendered; determining primary/ secondary coverage, such as for custodial information pertaining to a dependent; the diagnosis and treatment plan for orthodontics.

Notice to All Parties Completing this Form:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.