Dental Claim Form

CWA Local 1180

1. ☐ Dentist's pretreatment estimate ☐ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #

3. Carrier Name: CWA Local 1180 Scheduled Dental Benefit Plan
4. Carrier Address: 253 West 35th Street, 12th Floor
5. City: New York | 6. State: NY | 7. Zip: 10001

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 ☐ M ☐ F
15. Phone Number ( )
16. Zip Code
17. Relationship to Subscriber/Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY) / /
29. Marital Status ☐ Married ☐ Single ☐ Other
30. Gender ☐ M ☐ F

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

OTHER POLICIES

31. Is patient covered by another plan ☐ No (Skip 32–37) ☐ Yes: ☐ Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / /
35. Gender ☐ M ☐ F
36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status ☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student
40. Employer/School Name Address

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

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

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 ☐ Office ☐ Hosp. ☐ ECF ☐ Other
50. City
51. State
52. Zip Code
53. Radiographs or models enclosed? ☐ Yes, How many? ____ ☐ No
54. Is treatment for orthodontics? ☐ Yes ☐ No
If service already commenced:
Date appliances placed
Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No
If no, reason for replacement:
Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐ No ☐ Yes
Brief description and dates
57. Is treatment result of: ☐ auto accident? ☐ other accident? ☐ 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

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent								Primary							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

Total Fee	
Payment by other plan	
Max Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

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.

X
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City
65. State
66. Zip Code

Questions tel. 1 212-505-5050