

MARITIME ASSOCIATION - I.L.A. WELFARE FUND
11550 Fuqua, Suite 425
Houston, Texas 77034-4597
(281) 484-4343

Claim for Dental Expense Benefits

HOW TO FILE YOUR CLAIM:

1. Complete the Employee's Statement below.
2. Have your dentist complete the Attending Dentist Statement on the other side of this form.
3. ALL QUESTIONS MUST BE ANSWERED.

EMPLOYEE'S STATEMENT

| | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------|---------------|---------------------------------|--|
| Fully Complete For All Claims | Employee's Name (Please Print) _____ | | Birthdate (Mo., Day, Year) _____ | | Social Security Number _____ | |
| | Address: Street and Number _____ | | | | City, State and Zip Code _____ | |
| | Date last worked in the ILA industry _____ | | | | | |
| | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced | | Spouse's Social Security Number _____ | | Home Telephone Number _____ | |
| | Local Number _____ | | | | | |
| | If claim is for any child, is that child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name of spouse and name and address of Employer. | | | | | |
| | Name of Spouse _____ | | | | Spouse's Birthdate _____ | |
| | Name of Spouse's Employer _____ | | | Address _____ | | |
| | Do you or your family have: | | | | | |
| a) Other group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No c) Government insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Give name of Employer _____ and other insurance company _____ What type? _____ | | | | | | |
| b) Give group number _____ d) Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Give certificate number _____ | | | | | | |
| * If these expenses are covered by other insurance and the other carrier is primary (that is, pays first), don't file this claim until you have received the payment from the other insurance. Submit the explanation of benefits from the other carrier with this claim. | | | | | | |
| Complete For All Injuries | Date of the injury? _____ | | Where did the injury occur? _____ | | How did the injury occur? _____ | |
| | Is injury due to an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Employee or Dependent | Have you or will you file these bills for Worker's Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | Are you presently receiving Worker's Compensation for any illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | If yes, please explain _____ | | | | | |
| Are you presently receiving any payment from an employer while disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Complete Only For Dependent Claims | Name of Dependent _____ | | Birthdate _____ | | Relationship of Dependent _____ | |
| | <input type="checkbox"/> Married <input type="checkbox"/> Single | | | | | |
| If attending school give name of school _____ | | | | | | |
| Sign Here | Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. I hereby certify to the above statements. | | | | | |
| | I hereby authorize the release to and the use by Maritime Association-I.L.A. Welfare Fund of any medical or other information needed in processing this claim and certify the above information is correct. | | | | | |
| Date _____ Employee Sign Here _____ | | | | | | |

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

3. Company/Plan Name, Address, City, State, Zip Code

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder (Subscriber in #1) Last, First, Middle Initial, Suffix

3. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

| | | |
|-------------------------------|--------------------------------------------------------------------|--------------------------------------------|
| 6. Date of Birth (MM/DD/CCYY) | 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F | 8. Policyholder/Subscriber ID (SSN or ID#) |
|-------------------------------|--------------------------------------------------------------------|--------------------------------------------|

| | |
|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other |
|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

| | | |
|--------------------------------|---------------------------------------------------------------------|---------------------------------------------|
| 13. Date of Birth (MM/DD/CCYY) | 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F | 15. Policyholder/Subscriber ID (SSN or ID#) |
|--------------------------------|---------------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------|-------------------|
| 16. Plan/Group Number | 17. Employer Name |
|-----------------------|-------------------|

| | |
|---------------------|--|
| PATIENT INFORMATION | |
|---------------------|--|

| | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|
| 18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other | | 19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|

| 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code |
|--------------------------------------------------------------------------------|
| |

| | | |
|--------------------------------|---------------------------------------------------------------------|------------------------------------------------|
| 21. Date of Birth (MM/DD/CCYY) | 22. Gender <input type="checkbox"/> M <input type="checkbox"/> F | 23. Patient ID/Account # (Assigned by Dentist) |
|--------------------------------|---------------------------------------------------------------------|------------------------------------------------|

| | | | | | | | |
|-------------------|----------|-----|---------------------|-----------|--------------|--|--|
| 24. Breeding Date | 25. Area | 26. | 27. Tooth Number(s) | 28. Tooth | 29. Breeding | | |
|-------------------|----------|-----|---------------------|-----------|--------------|--|--|

| MISSING TEETH INFORMATION | Permanent | | | | | | | | | | | | | | | | Primary | | | | | | | | | | 32. Other Fee(s) | | |
|------------------------------------------|-----------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---------|---|---|---|---|---|---|---|---|---|------------------|--|--|
| | 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 | | | |
| 34. (Place an 'X' on each missing tooth) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 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 | 33.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. Other Fee(s) |
|--|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|---|---|---|---|---|---|---|---|---|---|------------------|

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---|---|---|---|---|---|---|---|---|---|--------------|--|--|--|--|--|
| 34. (Place an 'X' on each missing tooth) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | 33.Total Fee | | | | | |

| |
|-------------|
| 35. Remarks |
|-------------|

36. 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 prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

48. Name, Address, City, State, Zip Code _____

| | | |
|---------|--------------------|----------------|
| 49. NPI | 50. License Number | 51. SSN or TIN |
|---------|--------------------|----------------|

| | |
|------------------------|-----------------------------|
| 52. Phone Number () - | 52A. Additional Provider ID |
|------------------------|-----------------------------|

| | |
|------------------------|-------------------------------------|
| 38. Place of Treatment | 39. Number of Enclosures (00 to 99) |
|------------------------|-------------------------------------|

| | | | | | | |
|--------------------------------------------|-----------------------------------|------------------------------|--------------------------------|----------------------------------------|----------------------------------------|-----------------------------------|
| <input type="checkbox"/> Provider's Office | <input type="checkbox"/> Hospital | <input type="checkbox"/> ECF | <input type="checkbox"/> Other | <input type="checkbox"/> Radiograph(s) | <input type="checkbox"/> Oral Image(s) | <input type="checkbox"/> Model(s) |
|--------------------------------------------|-----------------------------------|------------------------------|--------------------------------|----------------------------------------|----------------------------------------|-----------------------------------|

| | |
|----------------------------------------------------------------------------------------|----------------------------------------|
| 40. Is Treatment for Orthodontics? | 41. Date Appliance Placed (MM/DD/CCYY) |
| <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) | |

| | | |
|-----------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------|
| 42. Months of Treatment Remaining | 43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY) |
|-----------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------|

45. Treatment Resulting from

| | | |
|------------------------------------------------------|----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Occupational illness/injury | <input type="checkbox"/> Auto accident | <input type="checkbox"/> Other accident |
|------------------------------------------------------|----------------------------------------|-----------------------------------------|

| | |
|-----------------------------------|-------------------------|
| 46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State |
|-----------------------------------|-------------------------|

| TREATING DENTIST AND TREATMENT LOCATION INFORMATION | |
|-----------------------------------------------------|--|
| 1. Name of treating dentist | |
| 2. Address of treatment location | |
| 3. City | |
| 4. State | |
| 5. Zip | |
| 6. Telephone number | |
| 7. Fax number | |
| 8. E-mail address | |
| 9. Name of treatment location | |
| 10. Address of treatment location | |
| 11. City | |
| 12. State | |
| 13. Zip | |
| 14. Telephone number | |
| 15. Fax number | |
| 16. E-mail address | |

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

| | |
|---------|--------------------|
| 54. NPI | 55. License Number |
|---------|--------------------|

| | |
|------------------------------------|---------------------------------|
| 56. Address, City, State, Zip Code | 56A. Provider Specialty Code |
|------------------------------------|---------------------------------|

| | |
|------------------------|----------------------------|
| 57. Phone Number () - | 58. Additional Provider ID |
|------------------------|----------------------------|