Refer Completed Claims and Questions to:
UFT Welfare Fund c/o
Connecticut General
Life Insurance Co.
P.O. Box 182531
Chattanooga, TN 37422-7531
1-800-577-0576

CIGNA HealthCare

# DENTAL FORM

UFT
UNITED FEDERATION OF TEACHERS
WELFARE FUND
LOCAL 2, AMERICAN FEDERATION OF TEACHERS, AFL-CIO

❑ **PRE-TREATMENT ESTIMATE**
(REQUIRED FOR INLAYS, CROWNS, LAMINATE VENEERS, BRIDGES, DENTURES, PERIODONTAL SURGERY OR WHEN EXPENSES WILL EXCEED $500 IN A 90 DAY PERIOD)

❑ **PAYMENT CLAIM**
PLEASE SUBMIT PRE-TREATMENT X-RAYS FOR NON-ROUTINE EXTRACTIONS AND PRE- AND POST-TREATMENT X-RAYS FOR ROOT CANAL THERAPY

❑ ACTIVE MEMBER
❑ RETIREE
❑ COBRA

❑ **Yes - Spouse/Domestic Partner is a UFT Member therefore eligible for Special C.O.B.**

Spouse/Domestic Partner Social Security Number

## MEMBER INFORMATION – See instructions on reverse side

| Member Name *(Please Print)* | Birthdate | Sex | Social Security # |
|---|---|---|---|
| | | | |

| Home Address | City | State | Zip Code | Telephone # |
|---|---|---|---|---|
| | | | | ( ) |

| School or Bureau | School Telephone # | Do you have G.H.I. medical coverage? |
|---|---|---|
| | ( ) | ❑ Yes ❑ No |

Name and Address of Other Company/Organization Providing Dental Benefits under which you are covered

## PATIENT INFORMATION

| Patient Name *(Please Print)* | Birthdate | Relationship to Member |
|---|---|---|
| | | |

## SPOUSE/DOMESTIC PARTNER INFORMATION – (Required if claim is for Spouse/Domestic Partner or Dependent Child)

| Spouse/Domestic Partner Name *(Please Print)* | Spouse/Domestic Partner Birthdate | Spouse/Domestic Partner Social Security # |
|---|---|---|
| | | |

Is spouse/domestic partner covered by another Dental Benefits Plan other than UFTWF? ❑ Yes ❑ No If yes, specify below.

| Name and Address of Other Company/Organization Providing Dental Benefits | Company/Organization Telephone # |
|---|---|
| | ( ) |

## AUTHORIZATION (Authorization to release information must be signed or payment will not be made)

**To Release Information:** I have reviewed the following treatment plan. I authorize release of any and all information relating to this claim.

Signed (Patient or Parent if Minor)_____ Date _____

**To Assign Benefits:** I hereby authorize payment directly to the below named dentist of the benefits otherwise payable to me. I understand I am financially responsible to the dentist for charges not covered by this assignment. This authorization is invalid unless the TAX ID # of the provider is given below.

Signed (Member) _____ Date _____

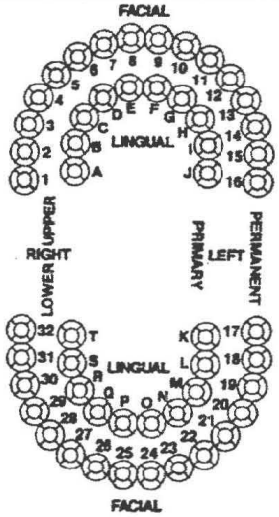
## DENTIST INFORMATION – (See instructions on the back regarding the need for x-rays)

| Dentist's Name *(Please Print)* | License # | Taxpayer ID # |
|---|---|---|
| | | |

| Street Address | City | State | Zip Code | Telephone # |
|---|---|---|---|---|
| | | | | ( ) |

| If prosthesis, is this the initial placement? | Date of Prior Placement |
|---|---|
| ❑ Yes ❑ No If no, the reason for replacement | |

**DENOTE MISSING TEETH WITH AN "X"**




*PLEASE CHART PROPOSED OR RENDERED TREATMENT*

Are radiographs enclosed? If yes, how many?
❑ Yes ❑ No

Is this claim the result of: Accident Injury ❑ Yes ❑ No
Motor Vehicle Injury ❑ Yes ❑ No

**PATIENT'S NAME** **AGE:**

| Tooth # or letter | Surface | Description of Service (including materials used) | Date Service Performed | Procedure Code | Fee |
|---|---|---|---|---|---|
| | | | | | |
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I hereby certify the accuracy of the pre-treatment estimate and/or procedures and, if completed, the dates of completion as listed above.
Was a pre-treatment filled by another provider? ❑ Yes ❑ No

Signed (Dentist) _____ Date _____

**TOTAL FEE CHARGED**