United Food & Commercial Workers Unions
and Food Employers Benefit Fund

6425 Katella Avenue, Cypress, CA 90630-5238
P.O. Box 6010, Cypress, CA 90630-0010
714-220-2297 • 562-408-2715 • 877-284-2320
www.scufcwfunds.com

Statement Of Claim For Dental Services

This claim is for: ☐ Self ☐ Child ☐ Spouse | Patient's Last Name | Patient's First Name | ☐ Male ☐ Female

Mailing Address *(if different from Participant)* Street: | City | State | Zip Code | Date of Birth (mm/dd/yyyy)

Participant Information *Supply all information requested below.*

Last Name | First Name | Mid. Initial | Social Security or Family ID Number

Mailing Address Street: | City | State | Zip Code | Date of Birth (mm/dd/yyyy)

Home phone ( ) | Work phone ( ) | Email Address | ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed

Employer | **Employer's Address** Street: | City | State | Zip Code

Is the patient covered under another dental plan? If "Yes", you must provide the information below. ☐ Yes ☐ No | Name of Other Plan | Name of Primary Insured

Other Plan's Phone ( ) | **Other Plan's Mailing Address** Street: | City | State | Zip Code

Spouse/Domestic Partner Information *Supply all information requested below.*

Last Name | First Name | Mid. Initial | Social Security or Family ID Number

I have reviewed the plan of treatment, and I authorize the attending dentist to release any information relating to this claim.

Participant's Signature ____ Date ____ If claim is for Spouse/D.P., (s)he must also sign ____ Date ____

To Be Completed By Dentist

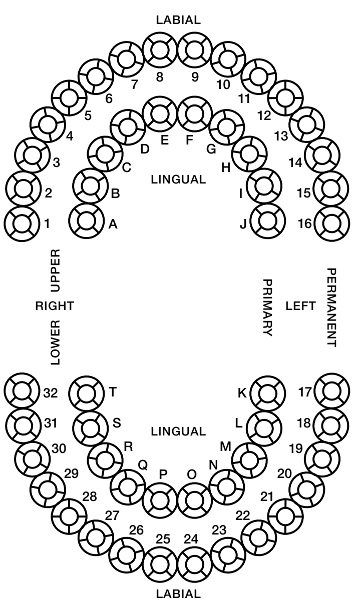
Dentist Last Name | First Name | Mid. Initial | Tax I.D. Number

Dentist's Mailing Address Street: | City | State | Zip Code | Dentist's Phone ( )

Date of examination | Are x-rays enclosed? How Many? ______ ☐ Yes ☐ No | Treatment result of accident? ☐ Yes ☐ No

Result of occupational injury ☐ Yes ☐ No | Is any of treatment for orthodontic purposes? ☐ Yes ☐ No | Patient covered by other plan? ☐ Yes ☐ No

PLEASE PLOT WORK



Indicate Missing Teeth With "X"

PRIOR APPROVAL RECOMMENDED ON TREATMENT PLANS EXCEEDING $500.

MOUNTED X-RAYS REQUIRED [Mark duplicates (L) (R)]

EXAMINATION AND TREATMENT RECORD LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

Tooth # Or Letter	Surfaces	Description Of Service Including X-rays, Prophylaxis, Materials Used, Etc.	Date Service Performed MM	DD	YY	ADA Procedure Number	Fee	Office Use Only
						TOTAL FEE CHARGED		

To Be Completed By Dentist And Patient

I hereby certify that the services listed above have been completed, and that the fees as shown are the total fees that have been charged to the patient.

Dentist's Signature ____ Date ____

I hereby authorize payment directly to the above-named dentist of the benefits otherwise payable to me.

Patient's Signature *(or parent if patient is a minor)* ____ Date ____

DENTIST SHOULD RETAIN LAST COPY FOR HIS OR HER RECORDS