ATTENDING DENTIST'S STATEMENT

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

INSURANCE CO. NAME AND ADDRESS

CWA Local 1014 "Freedom of Choice" Dental
658 W. Cuthbert Blvd.
Westmont, NJ 08108

1. PATIENT NAME

2. RELATIONSHIP TO EMPLOYEE — SELF | SPOUSE | CHILD | OTHER

3. SEX — M | F

4. PATIENT BIRTHDATE — MO. | DAY | YEAR

5. IF FULL TIME STUDENT — SCHOOL — CITY

6. EMPLOYEE/SUBSCRIBER NAME — FIRST MIDDLE LAST

7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.

8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS

CITY, STATE, ZIP

9. NAME OF GROUP DENTAL PROGRAM

10. EMPLOYER (COMPANY) NAME AND ADDRESS

11. GROUP NUMBER

12. LOCATION (LOCAL)

13. ARE OTHER FAMILY MEMBERS EMPLOYED? — EMPLOYEE NAME — SOC. SEC. NO.

14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? — DENTAL PLAN NAME — UNION LOCAL — GROUP NO. — NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT, OR PARENT IF MINOR) — DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (INSURED PERSON) — DATE

16. DENTIST NAME

17. MAILING ADDRESS

CITY, STATE, ZIP

18. DENTIST SOC. SEC. OR T.I.N.

19. DENTIST LICENSE NO.

20. DENTIST PHONE NO.

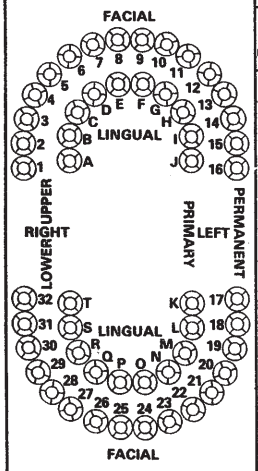
21. FIRST VISIT DATE — CURRENT SERIES

22. PLACE OF TREATMENT — OFFICE | HOSP. | ECF | OTHER

23. RADIOGRAPHS OR MODELS ENCLOSED? — NO | YES | HOW MANY?

	NO	YES	
24. Is Treatment Result Of Occupational Illness Or Injury?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. Is Treatment Result Of Auto Accident?			
26. Other Accident?			
27. Are Any Services Covered By Another Plan?			
28. If Prosthesis, Is This Initial Placement?			(If No, Reason For Replacement) — 29. Date Of Prior Placement
30. Is Treatment For Orthodontics?			If Services Already Commenced, Enter — Date Appliances Placed — Mos. Treatment Remaining

IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.

LINE NO.	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST) — DATE

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

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