

INSTRUCTIONS

MEMBER:

1. This form is used for two different purposes. Therefore, please indicate by **checking the appropriate box** if form is a **Pre-treatment Estimate** or is a **Claim for Payment**. See description below. Also check the box to indicate if you are presently an **active member or retiree** or **COBRA** eligible.

Pre-treatment Estimate – A pre-treatment estimate is only necessary if the dental course of treatment includes one or more of the following: **Periodontic Surgery, Inlays or Laminate Veneers, Crowns, Bridgework, Dentures** or when **expenses exceed \$500 in a period of 90 days**. You and your dentist will be advised as to treatment authorized and the extent to which the dental expense will be considered as covered under the UFTWF Scheduled Dental Benefit Plan. You will be responsible for charges that exceed the Plan maximum or are not authorized.

Claim for Payment – After dental work is performed, this form, with the box checked indicating that it is a **Claim for Payment** must be submitted whether or not a Pre-Treatment Estimate has been previously submitted.

2. Complete all items in member's section and patient section. include spouse or domestic partner information where applicable. If patient is an unmarried dependent child between the ages of 19 and 23 and attending school as a full time student, the name of the school must be given. Twenty-three (23) year old full time students are covered until the end of the calendar year or graduation, whichever comes first. Proof of the student's enrollment may be requested to process this claim.

3. Please be sure you have provided your **Social Security Number** in this and all correspondence.

4. "**Authorization to Release Information**" must always be signed whether form is **Pre-Treatment Estimate** or **Claim for Payment**. The benefits to which you are entitled will be paid to you the member, unless the claim is assigned. Only sign the "**Authorization to Assign Benefits**" if you wish payment to be sent directly to Dentist. If you assign benefits, you will be notified of the payments made so that you will know the portion of the bill not covered by this plan.

*Note – Form should be signed **after** you have reviewed the completed dentist section.*

5. The completed dental form should be **mailed to** the UFTWF Claims Administrator, Connecticut General Life Insurance Co. (formerly Healthsource-Provident), P.O. Box 182531, Chattanooga, TN 37422-7531. If you have any questions regarding your claim, please contact the **Dental Unit** at Connecticut General Life Insurance Co., 1-800-577-0576.

6. Claims submitted more than one (1) year after the date of service will not be honored for payment.

DENTIST:

1. Complete all applicable lines under Dentist Information.

2. If statement is for Pre-Treatment Estimate leave the date blank. Our estimate and your X-rays will be returned to you promptly. Estimates are subject to plan maximums and may be reduced by payments made before these services are rendered. The estimate is based on the assumption that at the time the patient receives the services he/she is covered by the Fund for benefits and that no significant change occurred in the condition of the mouth after this Pre-Treatment Estimate was issued..

Note – With claim for payment, please submit pre-treatment X-rays for non-routine extractions and pre- and post-treatment X-rays for root canal therapy. X-rays may also be requested for other services. Please include the member's Social Security Number on all submitted X-rays.