United Teachers of Seaford Trust Fund
Local 1780

# ORTHODONTICS FOR A DEPENDENT CHILD ONLY

RETURN THIS FORM TO
United Teachers of Seaford Trust Fund
c/o Daniel H. Cook Associates
1040 Avenue of the Americas,
24th Floor, New York, NY 10018
(212) 505-5050

| PATIENT NAME: (print last name first) | SEX ☐ M ☐ F | RELATIONSHIP TO MEMBER ☐ Self ☐ Child ☐ Spouse ☐ Other | PATIENT DATE OF BIRTH MO. DY. YR. |
|---|---|---|---|
| | | | |

| MEMBER NAME (print last name first) | Sex ☐ M ☐ F | MEMBER'S I.D. NUMBER | MEMBER DATE OF BIRTH MO. DY. YR. |
|---|---|---|---|
| | | | |

| HOME ADDRESS Number and Street | APT. | HOME PHONE (include area code) |
|---|---|---|
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| CITY | STATE | ZIP | EMPLOYER PHONE (include area code) |
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**MEMBER CERTIFICATION:**

I certify that the information given is correct and authorize release of any information necessary to process this claim.

*Member Sign Here* _____ *Date*

To be signed, if Benefits are to be paid directly to your doctor.
ASSIGNMENT OF BENEFITS:
I hereby assign to Dr. _____ the benefits I am entitled to as represented by this claim. I understand that I Am financially responsible for charges not covered and/or paid by this assignment.

Date _____ Member's Signature

| DENTIST NAME | IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | NO | YES | IF YES, ENTER BRIEF DESCRIPTION AND DATES |
|---|---|---|---|---|
| MAILING ADDRESS | IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT? | | | |
| | | | | |
| CITY, STATE, ZIP | ARE ANY SERVICES COVERED BY ANOTHER PLAN? | | | |
| DENTIST SOC. SEC. or T.I.N. DENTIST LICENSE NO. DENTIST PHONE NO. | IF PROSTHESIS, IS THIS INITIAL | | | (IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR EMPLOYMENT |
| FIRST VISIT DATE CURRENT SERIES PLACE OF TREATMENT Office Hosp. ECF Other RADIOGRAPHICS OR MODELS YES NO HOW MANY? | IS TREATMENT FOR ORTHODONTICS? | | | IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING |

| | USE CHARTING SYSTEM AT LEFT. DESCRIBE YOUR TREATMENT PLAN OR SERVICES COMPLETED | | | | | | OFF USE |
|---|---|---|---|---|---|---|---|
| | Tooth or Letter | Surface | DESCRIPTION OF SERVICE (including X-RAYS, PROPHYLAXIS, MATERIALS USED, etc) LINE NO. | Date Service Performed | CDT Procedure Number | FEE | |
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| – CHECK ONE ONLY – | | | | | TOTAL FEE CHARGED | | |

☐ DENTIST'S TREATMENT PLAN (PRE-DETERMINATION)
I hereby certify that the above procedures are necessary to be performed

Dentist's Signature Date

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES:
I hereby certify that the above procedures were rendered on the dates indicated:

Dentist's Signature Date

I am a specialist in:
☐ Orthodontics