RETURN THIS FORM TO:

TCU-MTA Trust Fund
1200 WILSHIRE BLVD., FIFTH FLOOR
LOS ANGELES, CA 90017
(562) 463-5090 (800) 427-5342

NOTICE: IT IS ILLEGAL TO FILE A FALSE OR FRAUDULENT CLAIM OR TO KNOWINGLY HELP SOMEONE ELSE FILE ONE. YOU MAY BE FINED OR SENT TO PRISON FOR DOING SO. YOU MAY ALSO BE REQUIRED TO PAY CIVIL DAMAGES

ATTENDING DENTIST'S STATEMENT

PATIENT NAME	RELATIONSHIP TO EMPLOYEE: SELF / SPOUSE / CHILD / OTHER	SEX: M / F	PATIENT BIRTHDATE: MO. / DAY / YEAR	IF FULL TIME STUDENT: SCHOOL / CITY

EMPLOYEE NAME: FIRST / MIDDLE / LAST — EMPLOYEE SOCIAL SECURITY #

NAME OF GROUP DENTAL PROGRAM

EMPLOYEE MAILING ADDRESS

EMPLOYER (COMPANY) NAME AND ADDRESS

CITY STATE ZIP

LOCAL — ARE OTHER FAMILY MEMBERS EMPLOYED? YES ☐ NO ☐ — EMPLOYEE NAME — SOC. SEC. NO. — NAME AND ADDRESS OF EMPLOYER

IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES ☐ NO ☐ — 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 (PATIENT, OR PARENT IF MINOR) ____________ DATE ____________

DENTIST'S INFORMATION — PLEASE PRESS FIRMLY

		NO	YES	
DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT OTHER ACCIDENT?			
CITY STATE ZIP	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT
DENTIST SOC. SEC. OR TI NO. / DENTIST LICENSE NO. / DENTIST PHONE NO.	IS TREATMENT FOR ORTHODONTICS?			RADIOGRAPHS OR MODELS ENCLOSED? NO / YES / HOW MANY?

TO THE DENTIST: PREDETERMINATION OF BENEFITS REQUIRED FOR CLAIMS IN EXCESS OF $250. THE MAXIMUM BENEFIT FOR X-RAYS IS $50.00 PER CALENDAR YEAR.

IDENTIFY MISSING TEETH WITH "X"

FACIAL — UPPER — LINGUAL — RIGHT — LEFT — PRIMARY — PERMANENT — LOWER — LINGUAL — FACIAL

Upper: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16; A B C D E F G H I J
Lower: 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32; K L M N O P Q R S T

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

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO.	DAY	YR.	PROCEDURE NUMBER	FEE	ADMINISTRATIVE USE 100%	90%	80%

REMARKS FOR UNUSUAL SERVICES

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	

Claim # ____________

Bill # ____________

For Administrative Office Use Only:

Date:____________

We have listed the allowance for each procedure. Benefits are payable after a $20.00 deductible at the percentage indicated. Maximum benefits are $2,000.00 per calendar year. Benefits are subject to coordination of benefits and prior benefits paid.

The member is eligible for service rendered through____________20________for listed procedures only.

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