

**RETURN THIS FORM TO:** 

**TCU-MTA Trust Fund**

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

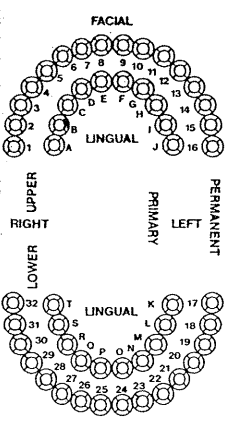
**NOTICE: IT IS ILLEGAL TO FILE A FALSE OR FRAUDULENT CLAIM OR TO KNOWINGLY HELP SOMEONE ELSE FILE ONE. YOU MAY BE FINED OR SENT TO PRISON FOR DOING SO. YOU MAY ALSO BE REQUIRED TO PAY CIVIL DAMAGES**

**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 EMPLOYEE NAME		MEMBERS EMPLOYED? SUC. SEC. NO.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	NAME AND ADDRESS OF EMPLOYER		
IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>		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.					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			
					SIGNED (PATIENT, OR PARENT IF MINOR)			
					DATE			

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		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'	EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN							ADMINISTRATIVE USE		
	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO. DAY YR.	PROCEDURE NUMBER	FEE		100%	90%	80%
										
REMARKS FOR UNUSUAL SERVICES										
I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED							TOTAL FEE CHARGED			
SIGNED (DENTIST)							MAX ALLOWABLE			
DATE							DEDUCTIBLE			
Claim # _____							CARRIER %			
Bill # _____							CARRIER PAYS			
							PATIENT PAYS			

**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.