STATEMENT OF DENTAL CLAIM **(509) 328-0300**

ATTENDING DENTIST'S STATEMENT

CHECK ONE
- [ ] DENTIST'S PRE-TREATMENT ESTIMATE
- [ ] DENTIST'S STATEMENT OF ACTUAL SERVICES

RETURN FORM TO

WASHINGTON-IDAHO CARPENTERS EMPLOYERS DENTAL TRUST
P.O. BOX 5434
SPOKANE, WASHINGTON 99205

EMPLOYEE SECTION

1. Patient name first m.i. last
2. Relationship to employee: SELF / CHILD / SPOUSE / OTHER
3. Sex m f
4. Patient Birthdate MM DD YYYY
5. If full time student school city
6. Employee name and mailing address
7. Employee soc. sec. number
8. Employee birthdate MM DD YYY
9. Employer (company)
10. Member's Marital Status: M / S / Wid. / Div. / Legal / Sep.
11. Is patient covered by another plan of benefits? Dental ____ Medical ____
12-a. Name and address of carrier(s)
12-b. Group no.(s)
13. Name and address of employer
14-a. Employee/subscriber name (if different than patient's)
14-b. Employee/subscriber soc. sec. number
14-c. Employee/subscriber birthdate MM DD YYYY
15. Relationship to patient: SELF / PARENT / SPOUSE / OTHER

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signed (Employee) Date

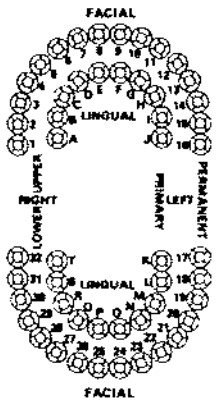
I hereby authorize payment directly to the below named dentist of the benefits otherwise payable to me.

Signed (Employee) Date

DENTIST SECTION

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?
24. Is treatment result of occupational illness or injury? No / Yes — 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 THRU TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE	AMOUNT CERTIFIED
		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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

SIGNED (DENTIST) DATE

TOTAL FEE CHARGED

MAX. ALLOWABLE

PRE-AUTHORIZATION CERTIFIES BENEFITS FOR 60 DAYS

PATENT PENDING