SOUTHERN CALIFORNIA DRUG BENEFIT FUND
P.O. BOX 27920, LOS ANGELES, CA 90027 (323) 666-8910

STATEMENT OF ORTHODONTIC SERVICES

PART 1

STATEMENT OF CLAIMS FOR ORTHODONTIC SERVICES

CLAIM IS FOR: ☐ Employee ☐ Spouse ☐ Child

PATIENT NAME:	**Date of Birth:**	**Sex:**
_____ ____ _____	____ / ____ / _____	☐ Male ☐ Female
First Name MI Last Name		

Part 2 **BLANK SPACES TO BE FILLED BY EMPLOYEE (PLEASE PRINT)**

Name of Employee:	**SSN:**	**DF#:**	**Employer:**
_____	_____ - ____ - _____	_____	_____

Home Address:

_____ _____ _____ _____

Street Address City State Zip Code

Is patient covered by another Orthodontic Program?

UFCW: ☐ Yes ☐ No **/ OTHER PLAN:** ☐ Yes ☐ No

Name and address of other Organization providing Benefits for Orthodontic Services:	**Spouse's Employer:**
_____	_____

I hereby certify the statements herein are complete, and I authorize the attending orthodontist to release any information on this claim.

_____ _____ _____

DATE EMPLOYEE'S SIGNATURE IF CLAIM IS FOR SPOUSE, S(HE) MUST ALSO SIGN

Part 3 -- TO BE COMPLETED BY ORTHODONTIST **PRIOR APPROVAL REQUIRED ON ALL TREATMENT PLANS**

1. Date of first visit (current series) _____ start date of banding_____
2. Phase: Single ☐ First of Two ☐ Second of Two ☐
3. Description of case and treatment plan (to include type of appliance) – Attach additional sheet if necessary.

4. **Cost of Case Analysis,** including cephalometrics, if used. $ _____
5. Fee is based on: ☐ A flat-rate basis, regardless of time present treatment takes. ☐ A charge-as-is-services-rendered basis.
6. If on the **FLAT-RATE** basis, complete below:
   Total orthodontic fee, exclusive of case analysis: $ _____
   Amount due upon completion of appliance construction: $ _____
   Monthly payments thereafter: $ _____per month for _____ months.
   Estimate number of months of active treatment for completion of this phase _____.
7. If on the **CHARGE-AS-SERVICES-RENDERED** basis, complete below:
   Amount due upon completion of appliance construction: $ _____
   How often do you expect to make adjustments: _____ Charge per adjustment: $ _____
   Estimated number of months of active treatment for completion of this phase: _____
8. Is your practice limited to Orthodontics? Yes ☐ No ☐ Member of _____Orthodontic Society.

_____ _____ _____ _____

Orthodontist Name (Print or Type) Street Address City and State Zip Code

_____ _____ _____ _____

Date Telephone Number Signature of Orthodontist Tax I.D. Number

ORTHODONTIC STUDY MODELS OR INTRAORAL PHOTOGRAPHS AND FULL MOUTH PERIAPICAL X-RAYS OR PANOREX X-RAY MUST ACCOMPANY CLAIM FORM.