OPERATING ENGINEERS TRUST FUNDS

I.U.O.E. LOCAL 12 HEALTH & WELFARE / PENSION / VACATION / DCP

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Request for Dental Review

Claim or preauthorization #: (up to 5 per review if same request. Must be the same patient) ☐ Check here if review is for a preauthorization			
Member ID: (Please do not send SSN#:)			
Patients Name:			
REQUEST- Detailed description of review request			
PROVIDER INFORMATION			
TIN:			
Treating provider name:			
CLAIM- Please attach a copy of the claim(s)			
NEA # (if applicable):			
DentalXChange # (if applicable):			
Contact			
Sender name:			
Contact number:			
Date:		**# of pages sent:**	

This form is not to be used to respond to a request for additional information

Please allow up to 30 days for review

Fax back to (626) 356-3566 or email to pservices@oefi.org