

PRE-AUTHORIZATION REQUIRED FOR ALL TREATMENT PLANS EXCEEDING \$350.00

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

EMPLOYEE / MEMBER INFORMATION **DENTAL CLAIM FORM**

1. PATIENT NAME			2. RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		3. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		4. PATIENT BIRTHDAY MONTH DAY YEAR			5. IF FULL TIME STUDENT SCHOOL CITY		
6. EMPLOYEE / MEMBER NAME FIRST MIDDLE LAST				DATE OF BIRTH MONTH DAY YEAR			7. SOCIAL SECURITY NUMBER			8. MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
9. EMPLOYEE ADDRESS CITY, STATE, ZIP						10. EMPLOYER NAME AND ADDRESS			11. SPOUSE'S NAME SPOUSE'S DATE OF BIRTH			
12. GROUP NUMBER		13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME			SOC. SEC. NO.		14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13					
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? DENTAL PLAN NAME UNION LOCAL GROUP NO.				16. NAME AND ADDRESS OF CARRIER IF APPLICABLE - PARENT WHO HAS LEGAL CUSTODY?								
I CERTIFY THAT THIS INFORMATION IS COMPLETE AND ACCURATE X PATIENT'S SIGNATURE DATE						I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP BENEFITS OTHERWISE PAYABLE TO ME X PATIENT'S SIGNATURE DATE						
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL, THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.												

DENTIST'S INFORMATION

17. DENTIST NAME				25. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTIONS AND DATES			
18. MAILING ADDRESS CITY, STATE, ZIP				26. IS TREATMENT RESULT OF AUTO ACCIDENT?							
				27. OTHER ACCIDENT?							
19. DENTIST SOC SEC OR TIN				20. DENTIST LICENSE NO.		21. DENTIST PHONE NO.		28. ARE THERE ANY SERVICES COVERED BY ANOTHER PLAN?			
22. FIRST VISIT DATE CURRANT SERIES		23. PLACE OF TREATMENT <input type="checkbox"/> OFFICE <input type="checkbox"/> ECF <input type="checkbox"/> HOSPITAL <input type="checkbox"/> OTHER		24. RADIOGRAPHY OR MODELS ENCLOSED? HOW MANY? <input type="checkbox"/> YES <input type="checkbox"/> NO		29. IF PROSTHESIS IS THIS A REPLACEMENT?		REASON FOR REPLACEMENT		31. DATE OF PRIOR PLACEMENT	
						30. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED ENTER		DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	

32. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.		USUAL AND CUSTOMARY SCHEDULE						
	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIAL USED ETC)	DATE OF SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	FEE	REGULAR CHARGES	SPECIAL CHARGES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.						TOTALS			
SIGNED (DENTIST) _____ DATE _____						DEDUCTIBLE			
MAIL COMPLETED FROM TO: DO NOT COMPLETE THIS SECTION PLAN ADMINISTRATOR FITZHARRIS & CO. INC. PO BOX 9182, FARMINGDALE, NY 11735 TEL. (516) 777-2244 1-800-321-1336						BALANCE			
						CO. INSURANCE			
						BENEFIT			
DATE OF EMPLOYMENT _____ EFFECTIVE DATE (DEPENDENT) _____						● MUST BE FURNISHED UNDER AUTHORITY OF LAW			
EFFECTIVE DATE (EMPLOYEE) _____ TERMINATION OF EMPLOYMENT _____									
DATE _____ SIGNATURE _____									

INSTRUCTIONS

For the Employee: Complete in full and sign the employee's information section. Any omissions may require that the form be returned to you.

If benefits are assigned to the provider, the EMPLOYEE / MEMBER MUST SIGN the authorization releasing payment.

Give the claim form to your dentist and he or she will complete the dentist's information section.

ADDITIONAL FORMS MAY BE OBTAINED FROM YOUR EMPLOYER.

For your Dentist: Complete the dentist's information section and mail this form to the address shown on the reverse side of this form.

NOTE: If your treatment plan involves charges in excess of \$350.00, pre-authorization is suggested. For pre-authorization, send to the address shown on the reverse side of this form. A copy will be returned to you showing the amount of benefits payable. Any x-rays submitted will be returned to you. When treatment is completed, indicate the dates of service in the column provided, sign and date the form and mail the form to the address shown on the reverse side of this form.