PRE-AUTHORIZATION REQUIRED FOR ALL TREATMENT PLANS EXCEEDING $350.00

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

DENTAL CLAIM FORM

EMPLOYEE/MEMBER INFORMATION

1. PATIENT NAME
2. RELATIONSHIP ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____
3. SEX MALE ☐ FEMALE ☐
4. PATIENT BIRTHDAY MONTH / DAY / YEAR
5. IF FULL TIME STUDENT SCHOOL CITY
6. EMPLOYEE/MEMBER NAME FIRST MIDDLE LAST DATE OF BIRTH
7. SOCIAL SECURITY NUMBER / /
8. MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED
9. EMPLOYEE ADDRESS
10. EMPLOYER NAME AND ADDRESS
11. SPOUSE NAME DATE OF BIRTH
CITY, STATE, ZIP
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

I HEARBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP BENEFITS OTHERWISE PAYABLE TO ME

PATIENT'S SIGNATURE DATE PATIENT'S SIGNATURE DATE

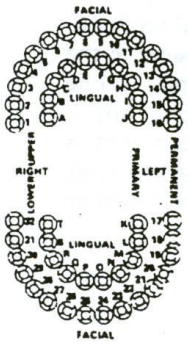
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL, THERETO, COMMITS A FRAUDULENT 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
18. MAILING ADDRESS
CITY, STATE, ZIP
19. DENTIST SOC SEC OR TIN ●
20. DENTIST LICENSE NO.
21. DENTIST PHONE NO.
22. FIRST VISIT DATE CURRANT SERIES
23. PLACE OF TREATMENT OFFICE | HOSP | ECF | OTHER
24. RADIOGRAPHY OR MODELS ENCLOSED? NO YES HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTIONS AND DATES
25. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
26. IS TREATMENT RESULT OF AUTO ACCIDENT			
27. OTHER ACCIDENT?			
28. ARE THERE ANY SERVICES COVERED BY ANOTHER PLAN?			
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

IDENTIFY MISSING TEETH WITH X



33. REMARKS OR UNUSUAL SERVICES

32. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIAL USED ETC)	DATE SERVICE PERFORMED MO DAY YEAR		PROCEDURE NUMBER	FEE	USUAL AND CUSTOMARY SCHEDULE: REGULAR CHARGES	SPECIAL CHARGES

TOTALS		
DEDUCTIBLE		
BALANCE		
CO. INSURANCE		
BENEFIT		

I HEARBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST) DATE

MAIL COMPLETED FORM 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

DATE OF EMPLOYMENT _____ EFFECTIVE DATE (DEPENDENT) _____
EFFECTIVE DATE (EMPLOYEE) _____ TERMINATION OF EMPLOYMENT _____
DATE _____ SIGNATURE _____

● MUST BE FURNISHED UNDER AUTHORITY OF LAW