Pre authorization Required For All Treatment Plans Exceeding $350.00

Check One:
☐ Dentists Pre - Treatment Estimate
☐ Dentists Statement of Actual Svc.

DENTAL CLAIM FORM

EMPLOYEE/MEMBER INFORMATION

Patient Name:	Relationship: ☐ self ☐ spouse ☐ child ☐ other	Sex: ☐ Male ☐ Female	Patient Birthdate: Month Day Year
Patient if full time student: School: City:	Employee/Member Name (first,mid,last):	Member Soc. Security Number:	Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed
Employee Address:	Group/Employee Name & Address:	Spouse's Name:	Spouse's Date of Birth:
Employee City, State, Zip:			
Are other family members employed?: Employee Name: Soc. Sec. #:		Name & Address of Employer:	
Is patient covered by another plan?	Dental Plan Name / Union Local / Group Number	Name and address of carrier	If applicable - Parent who has legal custody

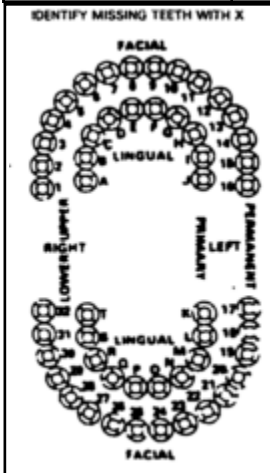
I HEARBY AUTHORIZE X-RAYS & ANY OTHER INFORMATION RELATING TO THIS CLAIM

Signed _____
(Patient or Parent if Patient is a Minor)

Any person who knowingly, and with intent to defraud any fund 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 fraudulant insurance act, which is a crime.

Dentists Information

Dentists Name:	Is Treatment Result of Occupational Illness or Injury?	No	Yes	If yes, enter brief description & dates:
Mailing Address:	Is Treatment Result of an Auto Accident? Other Accident?			If yes, enter brief description & dates:
City, State, Zip:	Are there any services covered by another plan?			If yes, enter brief description & dates:
First Visit Date:	If prosthesis is this a Replacement?			Reson for replacement
Soc./TIN, Lic. #, Phone: Treatment At? office Hosp EFC other	Radiography or models enclosed? Yes No How Many	Is treatment for orthodontics?		If services already commenced enter: Date appliances placed: Mos. treatment remaining:



33. REMARKS OR UNUSUAL SERVICES

Tooth or letter	Surface	Description of service Including: X-rays, Prophylaxis material used, etc.	Date service was performed: MO. DAY YR.	Procedure Number:	Fee	Usual & Customary Regular Charges:	Schedule Special Charges:

I HEARBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED
Dentist Signature: _____ Date: _____

Totals		
Deductible		
Balance		
CO. Insurance		
BENEFIT		

Date of Employment: _____ Effective Date (Dependent) _____

Effective Date (Employee) _____ Termination of Employment _____

DATE: _____ SIGNATURE: _____ MUST BE FURNISHED UNDER AUTHORITY OF LAW

MAIL COMPLETED FORM TO:
Do Not Complete This Section

PLAN ADMINISTRATOR FITZHARRIS & CO., INC.
PO BOX 9182 FARMINGDALE, N.Y. 11735-1336
(516) 777-2244 - FAX: (516) 777-5777 / 78