Dental Claim Statement
New York State School Trust

Check One:
- ☐ Dentist's Pre - Treatment Estimate
- ☐ Dentist's Statement of Actual Svc.

Pre authorization Required For All Treatment Plans Exceeding $300.00
For further assistance, please call us at: 1-516-777-2244

GE Financial Assurance
Employer Services Group

Mail Completed Form To:
Fitzharris & Company
P.O. Box 9182
Farmingdale, NY 11735-9182

PART 1 - EMPLOYEE'S STATEMENT - PLEASE PRINT

Name of Employee (F,M,L):	EE Soc. Security #:	Date of Birth: / /	Sex: M ☐ F ☐	Account #:
Employee's Complete Home Mailing Address (No.,street,city,state,zip):		Employers Name:		
Is Spouse Employed?: ☐ Yes ☐ No — Spouse's Name:		Spouse's Date of Birth: / /	Spouse's Soc. Security #: — —	
Name Of Patient: (fst, Lst, Mid) — Date of Birth / /	Relationship to Employee:	Does Employee Have Custody ☐ Yes ☐ No	Patients Social Security #	
Is patient covered by any other dental plan: ☐ Yes ☐ No	If Yes Give Name Of Carrier	Subscribers Name/ Relationship to Patient:	Group Number:	Check One Family ☐ Single ☐
Is Dependent (19 Yrs. or Older) a Full Time Student? Yes ☐ No ☐	If Yes School Name and City		Expected Date Of Graduation	

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to provider named below on this claim for the group dental benefits otherwise payable to me, but does not exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.

Signature Of Employee | Date

RELEASE AUTHORIZATION: I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health including HIV and/or AIDS related information to give any such information to GE Group Life Assurance Company (hereinafter "GEGLAC") and it's legal representatives; Any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, Third Party Administrator, the Medical Information Bureau, or any similar organization, institution or person, any employer, group planholder or certificateholder. If the record contains information relating to HIV test results, AIDS, alcohol or drug abuse or mental health care, enough of this information is also to be released to GEGLAC will be used in processing my claim for dental benefits.

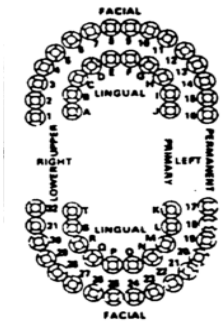
GEGLAC may redisclose such information for that purpose to the employer or union connected with the group dental benefits involved herein, the group planholder or certificate holder, or their representatives, Third Party Administrator, to any reinsurer, to my spouse and to any person or entity performing a business or legal function for the benefit of GEGLAC or the employer. This information may also be redisclosed as otherwise specifically permitted or required by law. This authorization or photocopies of it will be valid for the term of the coverage of the plan. The information released to GEGLAC will not be given, sold, or transfered to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

Signature Of Employee:	DATE:	Signature Of Dependent Patient (parent should sign for minor a child):	DATE:

PART II - ATTENDING DENTIST'S STATEMENT - PLEASE PRINT

Dentists Name: (First, Last)	Dentists Phone Number	Name Of Patient	Is dentist related to Paitent by blood or marriage? ☐ Yes ☐ No Relationship: ———	
Dentists Office Location (No.,street,city,state,zip):		ORTHODONTIC TREATMENT > Date Appliance Inserted	Expected Treatment: Duration: _____Months	Class oF Malocclusion: ☐ 1 ☐ 2 ☐ 3
Dentists Tax ID:	New Location? ☐Yes ☐ No More than 1 office? ☐Yes ☐ No	Is Treatment a result of an accident? ☐Yes ☐ No (if yes) ☐ At Work ☐ Auto ☐ Other	For crown,bridge,or other prothesis:Is this initial placement? ☐Yes ☐ No	If not,Date of prior placement? Mo. _____ Yr. _____
Rermarks:		Prior Partial? ☐Yes ☐ No	If No.Date Of Extraction	Teeth involved in prior prothesis:

IDENTIFY MISSING TEETH WITH X



33. REMARKS OR UNUSUAL SERVICES

Tooth Number or Letter	Surface	Description of service Including: X-Rays, Prophylaxis, materials, etc Line No.	Date service wasp performed:	Procedure#:	Fee:	For Administrative use ONLY

Radiographs or Model Enclosed: ☐Yes ☐ No

Dentist Signature: | Date: | ☐ X-rays returned to dentist

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

COMPLETE & RETURN TO:

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