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 MONTH DAY YEAR ___/___/___	7. SOCIAL SECURITY NUMBER ___-___-___	8. MARITAL STATUS ☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED

9. EMPLOYEE ADDRESS	10. EMPLOYER NAME AND ADDRESS	11. SPOUSE'S NAME
CITY, STATE, ZIP		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

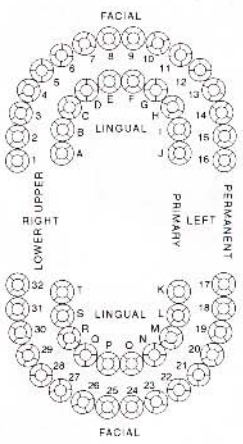
PATIENT'S SIGNATURE DATE

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	26. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	27. OTHER ACCIDENT?			
CITY, STATE, ZIP	28. ARE THERE ANY SERVICES COVERED BY ANOTHER PLAN?			
19. DENTIST SOC SEC OR TIN 20. DENTIST LICENSE NO. 21. DENTIST PHONE NO. ●	29. IF PROSTHESIS IS THIS A REPLACEMENT?			REASON FOR REPLACEMENT / 31. DATE OF PRIOR PLACEMENT
22. FIRST VISIT DATE CURRANT SERIES / 23. PLACE OF TREATMENT ☐OFFICE ☐ECF ☐HOSPITAL ☐OTHER _____ / 24. RADIOGRAPHY OR MODELS ENCLOSED? ☐YES ☐NO HOW MANY?	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 OF SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	FEE	USUAL AND CUSTOMARY SCHEDULE REGULAR CHARGES	USUAL AND CUSTOMARY SCHEDULE SPECIAL CHARGES
					TOTALS		
					DEDUCTIBLE		
					BALANCE		
					CO. INSURANCE		
					BENEFIT		

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

SIGNED (DENTIST) _____ DATE _____

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

DATE OF EMPLOYMENT _____ EFFECTIVE DATE (DEPENDENT) _____

EFFECTIVE DATE (EMPLOYEE) _____ TERMINATION OF EMPLOYMENT _____

DATE _____ SIGNATURE _____

● MUST BE FURNISHED UNDER AUTHORITY OF LAW