

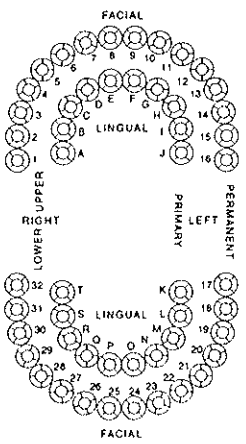
EMPLOYEE / MEMBER INFORMATION DENTAL CLAIM FORM

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?			
		29. IF PROSTHESIS IS THIS A REPLACEMENT?		REASON FOR REPLACEMENT	
22. FIRST VISIT DATE CURRENT SERIES		23. PLACE OF TREATMENT <input type="checkbox"/> OFFICE <input type="checkbox"/> ECF <input type="checkbox"/> HOSPITAL <input type="checkbox"/> OTHER		24. RADIOGRAPHS OR MODELS ENCLOSED? HOW MANY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		30. IS TREATMENT FOR ORTHODONTICS?		31. DATE OF PRIOR PLACEMENT	
				IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	

IDENTIFY MISSING TEETH WITH X 	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
33. REMARKS OR UNUSUAL SERVICES								

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

SIGNED (DENTIST) _____ DATE _____

MAIL COMPLETED FROM TO: **PLAN ADMINISTRATOR FITZHARRIS & CO. INC.**
 DO NOT COMPLETE THIS SECTION
 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 _____

TOTALS		
DEDUCTIBLE		
BALANCE		
CO. INSURANCE		
BENEFIT		

MUST BE FURNISHED UNDER AUTHORITY OF LAW

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.