

**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 \_\_\_\_\_

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?	
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		29. IF PROSTHESIS IS THIS A REPLACEMENT?	
						30. IS TREATMENT FOR ORTHODONTICS?	
						31. DATE OF PRIOR PLACEMENT	
						REASON FOR REPLACEMENT	
						DATE APPLIANCES PLACED	
						MOS. TREATMENT REMAINING	

<p>IDENTIFY MISSING TEETH WITH X</p> <p>33. REMARKS OR UNUSUAL SERVICES</p>	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

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**

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**

## 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.