PRE-AUTHORIZATION SUGGESTED FOR ALL TREATMENT PLANS EXCEEDING $350.00

CHECK ONE ☐ DENTIST'S PRE-TREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

EMPLOYEE / MEMBER INFORMATION

DENTAL CLAIM FORM

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
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? SOC. SEC. NO.
EMPLOYEE NAME
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

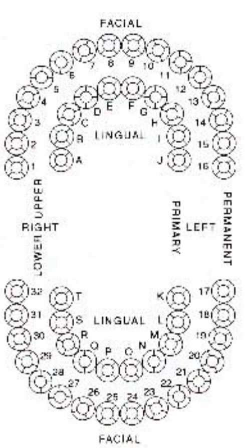
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL, THERETO, COMMITS A FRAUDULENT 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
18. MAILING ADDRESS
CITY, STATE, ZIP
19. DENTIST SOC SEC OR TIN ●
20. DENTIST LICENSE NO.
21. DENTIST PHONE NO.
22. FIRST VISIT DATE CURRENT SERIES
23. PLACE OF TREATMENT ☐ OFFICE ☐ ECF ☐ HOSPITAL ☐ OTHER ________
24. RADIOGRAPHS OR MODELS ENCLOSED? ☐ YES ☐ NO HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTIONS AND DATES
25. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
26. IS TREATMENT RESULT OF AUTO ACCIDENT?			
27. OTHER ACCIDENT?			
28. ARE THERE ANY SERVICES COVERED BY ANOTHER PLAN?			
29. IF PROSTHESIS IS THIS A REPLACEMENT?			REASON FOR REPLACEMENT / 31. DATE OF PRIOR PLACEMENT
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	SPECIAL CHARGES

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

SIGNED (DENTIST) ________________ **DATE** ________

TOTALS		
DEDUCTIBLE		
BALANCE		
CO. INSURANCE		
BENEFIT		

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