DENTAL CLAIM FORM

IMPORTANT NOTICE
PRE-TREATMENT REVIEW
FOR $500 OR MORE
Please Include X-Rays
Note: There is a yearly $2000 maximum
See Instructions on Reverse Side

RETURN THIS FORM TO

SOCIAL SERVICE EMPLOYEES UNION LOCAL 371 WELFARE FUND
1501 Broadway, Suite 450 • New York. N.Y. 10036
(212) 777-9000, ext. 3506

MEMBER

OFFICE USE ONLY

PATIENT NAME (Print Last Name First)

SEX ❑ M ❑ F

RELATIONSHIP TO MEMBER ❑ Self ❑ Child ❑ Spouse ❑ Other________

PATIENT DATE OF BIRTH MO DY YR

MEMBER NAME (Print Last Name First)

SEX ❑ M ❑ F

SOCIAL SECURITY NUMBER

Is this the first dental claim filed by you? ❑ YES ❑ NO

HOME ADDRESS (Include Zip Code)

APT.

HOME PHONE (Include area code)

MEMBER'S PAYROLL TITLE

Employed by NYC Dept. of

Is your mailing address different from last claim filed? ❑ YES ❑ NO

OFFICE PHONE (Include area code)

IS YOUR SPOUSE EMPLOYED? ❑ YES ❑ NO

IF 'YES' GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER AND SPOUSE'S SOCIAL SECURITY NUMBER

ARE DENTAL BENEFITS AVAILABLE FROM ANY OTHER CARRIER FOR THIS PATIENT?
❑ YES ❑ NO IF YES, SPOUSE BIRTHDATE ———MONTH ——DAY——YR

IF 'YES' GIVE NAME OF CARRIER AND I.D. NO. OF SUBSCRIBER

I certify that the information given is correct and authorize release of any information necessary to process this claim. Benefits are not available under any other group plan except as indicated above.

Signature Date

OFFICE USE ONLY	COB	DEP ST	SUFFIX	BY	DATE

DENTIST

DENTIST NAME

IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY/ ❑ NO ❑ YES

IF YES, ENTER BRIEF DESCRIPTION AND DATES

MAILING ADDRESS

IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?

CITY, STATE, ZIP

IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ❑ YES ❑ NO

IF 'NO', REASON FOR REPLACEMENT

DATE OF PRIOR PLACEMENT

DENTIST SOC. SEC. or T.I.N.

DENTIST LICENSE NO.,

DENTIST PHONE NO.

FIRST VISIT DATE CURRENT SERIES

PLACE OF TREATMENT Office Hosp Other

RADIOGRAPHICS OR MODELS YES ❑ NO ❑ HOW MANY?

IS TREATMENT FOR ORTHODONTICS? YES ❑ NO ❑

Indicate missing tooth with 'X'

FACIAL

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

LINGUAL

LINGUAL

17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

FACIAL

USE CHARTING SYSTEM AT LEFT. DESCRIBE TREATMENT PLAN OR SERVICES COMPLETED

Tooth or Letter	Sur-face	DESCRIPTION OF SERVICE (Including X-RAYS, PROPHYLAXIS, MATERIALS USED, etc.) LINE NO	Date Service Performed	CDT Procedure Number	FEE	OFFICE USE

—CHECK ONE ONLY—

TOTAL FEE CHARGED

❑ DENTIST'S TREATMENT PLAN
PRE-TREATMENT REVIEW
I hereby certify that the above procedures are necessary to be performed.

Signature Date

❑ DENTIST'S STATEMENT OF ACTUAL SERVICES
I hereby certify that the above procedures were rendered on the dates indicated.

Dentist's Signature Date

I am a specialist in: ❑ Orthodontics ❑ Endodontics ❑ Oral Surgery ❑ Periodontics ❑ Other

PATIENT CERTIFICATION OF SERVICES
I certify that to the best of my knowledge the dental procedures listed above were actually performed and the dates on which they were performed are accurate. Signature Date
PLEASE NOTE THAT THIS MUST BE SIGNED BY THE MEMBER/PATIENT IN ORDER FOR THIS CLAIM TO BE PROCESSED

THIS FORM MAY HAVE TO BE RETURNED IF IT IS INCOMPLETE OR INCORRECT

NOTICE TO MEMBERS

- **THERE IS A $2,000 YEARLY DENTAL PLAN MAXIMUM PER COVERED PERSON PER PLAN YEAR (JAN. 1 THROUGH DEC. 31).**

- **PRE-TREATMENT REVIEW BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST'S CHARGES WILL AMOUNT TO $500 OR MORE. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-TREATMENT REVIEW. Pre-Treatment Review by the Fund's Dental Consultant is limited to the review of the course of treatment proposed; it does not include approval of payment for services not covered under the Dental Plan, or of the fees charged by non-participating dentists.**

POST-TREATMENT REVIEW

- **Completed treatment amounting to $1,000 or more requires examination of patient by Fund's Consultant Dentist before payment is made.**

- **CLAIM MUST BE SUBMITTED WITHIN ONE YEAR AFTER COMPLETION OF COURSE OF DENTAL TREATMENT.**

- **Bring a claim form with you when you visit your dentist. Complete your part, give all the information required. DISCUSS FEES BEFORE SERVICES ARE PERFORMED. If you have any questions about your benefits, contact the Fund office.**

- **Participating Dentists have agreed to accept payment directly from the Welfare Fund, and there is no out-of-pocket expense to the patient for COVERED services up to the $2,000 yearly maximum. You may obtain the names and addresses of Participating Dentists located conveniently to your home or work location from the Fund Office. This is an information service for covered members and eligible dependents: *The Fund does not recommend the services of any particular dentist.***

- **Non-participating dentists have no agreement with the Fund and must be paid by the member or covered patient. The member must file a claim with the Fund for reimbursement, and payment will be made only to the member in accordance with the Fund's Schedule of Dental Benefits.**

- **If claim is for dependent student over age 19, attach proof of school attendance.**

- **PLEASE MAKE SURE YOU HAVE SIGNED THE DENTAL PROCEDURE CERTIFICATION BOX ON THE BOTTOM OF THE CLAIM FORM.**

- Mail this form to: SOCIAL SERVICE EMPLOYEES UNION
  LOCAL 371 BENEFITS FUND
  : (212) 777-9000, Ext. 3506
  1501 Broadway, Suite 450 • New York, NY 10036

NOTICE TO DENTISTS

- **Please note that copies of signatures and "signatures on file" will not be accepted as valid by the Fund office and the claim form will be returned to you.**

FUND'S DENTAL CONSULTANT REMARKS

ANYONE INTENTIONALLY MISUSING THIS FORM FOR THE PURPOSE OF OBTAINING IMPROPER PAYMENTS IS SUBJECT TO APPROPRIATE ACTION

442