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

Chappaqua Congress of Teachers

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

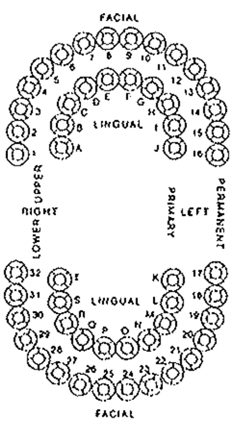
17. DENTIST NAME
18. MAILING ADDRESS

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

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 show 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.