PRE-AUTHORIZATION REQUIRED FOR ALL TREATMENT PLANS EXCEEDING $250.00

DENTAL CLAIM FORM

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

EMPLOYEE'S INFORMATION

DENTAL BENEFIT CLAIM FORM

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER ______	3. SEX MALE ☐ FEMALE ☐	4. PATIENT BIRTHDAY MONTH / DAY / YEAR	5. IF FULL TIME STUDENT SCHOOL CITY
6. EMPLOYEE NAME FIRST MIDDLE LAST	DATE OF BIRTH	7. SOCIAL SECURITY NUMBER ____/____/____		8. MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED
9. EMPLOYEE ADDRESS		10. EMPLOYER NAME AND ADDRESS **PFT WELFARE FUND**		11. SPOUSE NAME DATE OF BIRTH
CITY, STATE, ZIP				
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

I HEARBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP BENEFITS OTHERWISE PAYABLE TO ME

EMPLOYEE'S SIGNATURE (SIGNATURE OF DEPENDENT SPOUSE IS NOT ACCEPTABLE) ________ DATE ________

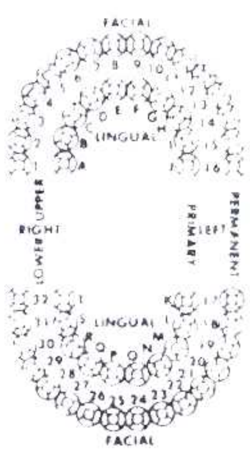
SIGNED EMPLOYEE ________ DATE ________

PLEASE NOTE: BENEFITS CAN ONLY BE ASSIGNED TO PARTICIPATING PROVIDERS

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		26. IS TREATMENT RESULT OF AUTO ACCIDENT			
		27. OTHER ACCIDENT?			
CITY, STATE, ZIP		28. ARE THERE ANY SERVICES COVERED BY ANOTHER PLAN?			
19. DENTIST SOC SEC OR TIN •	20. DENTIST LICENSE NO. 21. DENTIST PHONE NO.	29. IF PROSTHESIS IS THIS A REPLACEMENT?			REASON FOR REPLACEMENT / 31. DATE OF PRIOR PLACEMENT
22. FIRST VISIT DATE CURRANT SERIES	23. PLACE OF TREATMENT OFFICE / HOSP / ECF / OTHER; 24. RADIOGRAPHY OR MODELS ENCLOSED? NO / YES / HOW MANY?	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 SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	FEE	USUAL AND CUSTOMARY REGULAR CHARGES	SCHEDULE SPECIAL CHARGES

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

SIGNED (DENTIST) ________ DATE ________

TOTALS	
DEDUCTIBLE	
BALANCE	
CO. INSURANCE	
BENEFIT	

MAIL COMPLETED FORM TO:

PFT WELFARE FUND
303 Sunnyside Boulevard - Suite 90, Plainview NY 11803
(516) 349-1312

DO NOT COMPLETE THIS SECTION

DATE OF EMPLOYMENT ________ EFFECTIVE DATE (DEPENDENT) ________

EFFECTIVE DATE (EMPLOYEE) ________ TERMINATION OF EMPLOYMENT ________

DATE ________ SIGNATURE ________

• MUST BE FURNISHED UNDER AUTHORITY OF LAW