IMPORTANT NOTICE
PRE-TREATMENT REVIEW
FOR $300 OR MORE
Please Include X-Rays
Note: There is a yearly $1500 maximum
See Instructions on Reverse Side

DENTAL CLAIM FORM

RETURN THIS FORM TO

SOCIAL SERVICE EMPLOYEES UNION LOCAL 371 WELFARE FUND
P.O. BOX 672, COOPER STATION, NEW YORK, N.Y. 10276-0672
(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

MAILING ADDRESS

CITY, STATE, ZIP

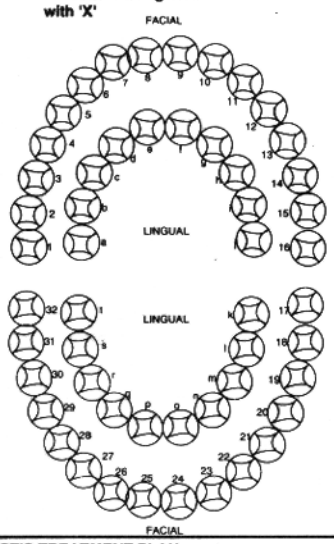
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY/ ❑ NO ❑ YES IF YES, ENTER BRIEF DESCRIPTION AND DATES

IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?

DENTIST SOC. SEC. or T.I.N.	DENTIST LICENSE NO.,	DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ❑ YES ❑ NO	IF 'NO', REASON FOR REPLACEMENT	DATE OF PRIOR PLACEMENT

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'



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

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

--CHECK ONE ONLY--

❑ 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

TOTAL FEE CHARGED

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