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 SERVICE

DENTAL BENEFIT CLAIM FORM

EMPLOYEE'S INFORMATION

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
CITY, STATE, ZIP
10. EMPLOYER NAME AND ADDRESS
PFT WELFARE FUND
11. SPOUSE NAME DATE OF BIRTH

12. GROUP NUMBER **433574**
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

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

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

SIGNED EMPLOYEE DATE

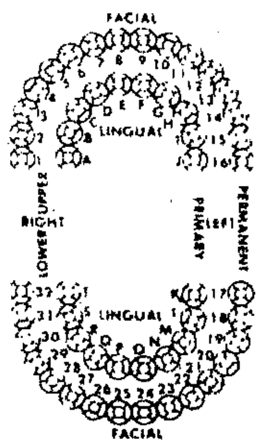
PLEASE NOTE: BENEFITS CAN ONLY BE ASSIGNED TO PARTICIPATING PROVIDERS

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 CURRANT SERIES
23. PLACE OF TREATMENT OFFICE HOSP ECF OTHER
24. RADIOGRAPHY OR MODELS ENCLOSED? NO YES 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 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 80, 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