# **Dental Claim Form**

Dentist's pre-treatment estimate Specialty (see backside) Dentist's statement of actual services

# Pre-Authorization \$500 Required

# MAIL COMPLETED FORM TO:

Yonkers Federation of Teachers Welfare Fund Dental Benefit 35 East Grassy Sprain Road, Suite 502 Yonkers, NY 10710 914-793-0393



	Patient Name (Last, First, Middle)				Address				City				State
PATIENT	Date of Birth (MM/DD/YYYY) Patient ID #				Sex		SAME TO SAME T	Phone Number			Zip Code		
۵	Relationship to Subscriber/Employee:						The same of the sa	Employer/School NameAddress					-
	SSN#					Г		is Patient covered by another plan				Poli	cy #
SUBSCRIBER INFROMATION	Subscriber/Employee Name (Last, First, Middle)					AGE		□No □Yes Other Subscriber's Name					
						COVERAGE							
	(				Phone Number )		/ / I			Sex			
	City			Zip Code		ОТНЕВ	Employer/School           NameAddress						
BER	Date of Birth (MM/DD/YYYY)  Marital Sta			Other	Sex								
SCRII	I have been informed of the treatment plan and associated fees. I agree to be resp					e for all Employer/School							
SUB	charges for dental services and malerials not paid by my dental benefit plan, unless th dentist or dental practice has a contractual agreement with my plan prohibiting all or a charges. To the extent permitted under applicable law, I authorize release of any inform						Name Address  I hereby authorize payment of the dental benefits otherwise payable to me directly to the						
	to this claim.						below named dental entity.						
	X						X_ Signed (Em	X					-
	Name of Billing Dentist or Dental Entity					e Num	ber		Provider ID #		Dentist Soc. Sec. or T.I,N.		T.I.N.
BILLING DENTIST	Address					st Lice	nse#		First visit date of current		Place of treatment		
								series:			□Office □Hosp. □ECF □Other		
	City State Zip Code					Radiographs or models  Yes, How many?					nent for orthodontics?  Yes No ready commenced:		
	If prosthesis (crown, bridge, dentures), is this If no, reason for replacement:									Date appliance	The state of the s		
co.	initial placement?												
Is treatment result of occupational illness or injury? No Yes Is treatment result of: \( \text{\text}\) auto accident? \( \text{\text}\) other accident? \( \text{\text}\) neither Brief description and dates													
Diagnosis Code Index (optional)													
1	22	3.	4	l	5			6	7.		8	Т	
Date (MM/DD/YYY)   Tooth   Surface   Diagnosis Index #   Procedure Cod								Descri	escription Fee			Adm	in. Use Only
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-	<del>                                      </del>							-				1	
												1	
Identify all missing teeth with "X" Permanent						Primary To			al Fee				
					BCD		FGHI			in			
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 T S R Remarks for unusual services							ONML	The state of the s				-	
Deductible  Carrier %													
Carrier pays													
									Patient pays				
I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those										ent was performe	d		
procedures.  City												State	Zip Code
X City State Zip Coc X Signed (Treating Dentist) License # Date (MM/DDXXXX)													185



# YONKERS FEDERATION OF TEACHERS WELFARE FUND DENTAL BENEFIT

35 East Grassy Sprain Road, Suite 502 Yonkers, NY 10710

This Form Will Have to Be Returned if it is incomplete or Incorrect

## NOTICE TO MEMBERS

Per-Treatment Authorization Required for \$500 or More

ANY PROPOSED DENTAL TREATMENT PROGRAM WITH DENTIST'S CHARGES OF \$500 PER COURSE OF TREATMENT OR MORE (DENTIST'S ACTUAL CHARGES) MUST BE CERTIFIED BY THE WELFARE FUND'S DENTAL CONSULTANT BEFORE THE TREATMENT IS BEGUN. X-RAYS MUST BE INCLUDED IF THE CLAIM IS \$500 PER COURSE OF TREATMENT OR MORE. A claim submitted for pre-treatment authorization will be returned to the dentist indicating the pre-treatment authorization decision. The pre-treatment authorization will be sent simultaneously to you arid to the dentist. Work related to this claim, which was submitted for Pre-Treatment Authorization, must be completed within one year from the date of approval.

- CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS AFTER COMPLETION OF DENTAL SERVICES.
- Claim forms are available at the Fund Office.
- TAKE 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 questions about benefits contact the Welfare Fund office or the Fund's Dental Consultant at (212) 505-5050.
- A COVERED PATIENT MAY GO TO ANY DENTIST, ANYWHERE, AND THE AMOUNT OF PAYMENT IS THE SAME REGARDLESS OF DENTIST CHOSEN.
- Mail your claim form to: Yonkers Federation of Teachers Welfare Fund at the address noted above.

## **NOTICE TO DENTISTS**

Complete all required statements, itemize all proposed services and fees, include X-rays and return form to the Welfare Fund at the address noted above. You will be advised if proposed procedures have been approved. Pre-treatment authorization means that the services are warranted, but Is not a guarantee of payment. Benefits are payable as long as patient remains eligible for this dental coverage on the date treatment is rendered.

Pre-treatment Authorization must be filed not later than 30 days after examination.

If services rendered am for emergency treatment, due to an accidental injury, Authorization will not be required.

## **INSTRUCTIONS FOR SERVICES LESS THAN \$500**

If the estimated charges will be less than \$500, Pre-Treatment Authorization is not required.

## INSTRUCTIONS TO DENTIST

Complete all required statements, including present condition, description of services and dates performed. Return completed form to member or the Fund office.

#### INSTRUCTIONS TO MEMBER

When treatment has been completed, your dentist will return claim form to you. At this time complete the employee section, sign, and send the claim form to the Fund office at the address noted at the top of the page.

## **IMPORTANT NOTICE!**

Any person who knowingly and with the intent to defraud or deceive the Welfare Fund files an application for coverage or statement of claim containing any false or misleading information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime.