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

YFT

PATIENT

Patient Name (Last, First, Middle) | Address | City | State

Date of Birth (MM/DD/YYYY) / / | Patient ID # | Sex ☐M ☐F | Phone Number ( ) | Zip Code

Relationship to Subscriber/Employee:
☐Self ☐Spouse ☐Child ☐Other_____

Employer/School
Name_____ Address_____

SUBSCRIBER INFROMATION

SSN#

Subscriber/Employee Name (Last, First, Middle)

Address | Phone Number ( )

City | State | Zip Code

Date of Birth (MM/DD/YYYY) / /

Marital Status ☐Married ☐Single ☐Other

Sex ☐M ☐F

I have been informed of the treatment plan and associated fees I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER COVERAGE

Is Patient covered by another plan ☐No ☐Yes | Policy #

Other Subscriber's Name

Date of Birth (MM/DD/YYYY) / / | Sex ☐M ☐F | Plan/Program Name

Employer/School
Name_____ Address_____

Employer/School
Name_____ Address_____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

Name of Billing Dentist or Dental Entity | Phone Number ( ) | Provider ID # | Dentist Soc. Sec. or T.I.N.

Address | Dentist License # | First visit date of current series: | Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other

City | State | Zip Code | Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | Is treatment for orthodontics? ☐Yes ☐No
If service already commenced:
Date appliances placed _____ Total mos of treatment remaining _____

If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No
If no, reason for replacement: _____ Date of prior placement: _____

Is treatment result of occupational illness or injury? ☐No ☐ Yes
Brief description and dates_____

Is treatment result of: ☐auto accident? ☐other accident? ☐neither
Brief description and dates_____

Diagnosis Code Index (optional)
1 _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin Use Only

Identify all missing teeth with "X"

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Remarks for unusual services

Total Fee	
Payment by other plan	
Max. Allowable	
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 procedures.

X_____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

Address where treatment was performed

City | State | Zip Code