PRE-AUTHORIZATION REQUIRED FOR ALL
TREATMENT PLANS EXCEEDING $350.00

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

DENTAL CLAIM FORM

EMPLOYEE'S INFORMATION

PATIENT NAME	RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER ____	SEX MALE ☐ FEMALE ☐	PATIENT BIRTHDAY MONTH / DAY / YEAR	IF FULL TIME STUDENT SCHOOL CITY
EMPLOYEE/MEMBER NAME FIRST MIDDLE LAST	DATE OF BIRTH	SOCIAL SECURITY NUMBER / /	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED	
ADDRESS		GROUP/EMPLOYEE NAME AND ADDRESS	SPOUSE NAME	DATE OF BIRTH
CITY, STATE, ZIP				
ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME	SOC. SEC. NO.	NAME AND ADDRESS OF EMPLOYER		
IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER
IF APPLICABLE - PARENT WHO HAS LEGAL CUSTODY?				

I HEREBY AUTHORIZE RELEASE OF X-RAYS AND ANY OTHER INFORMATION RELATING TO THIS CLAIM

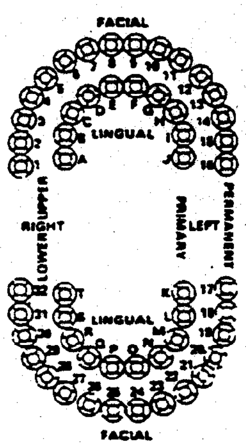
SIGNED ______________________________
(Patient or Parent if Patient is a Minor)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD THE FUND OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL, THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

DENTIST'S INFORMATION

DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTIONS AND DATES
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT / OTHER ACCIDENT?			
CITY, STATE, ZIP	ARE THERE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SOC SEC OR TIN • DENTIST LICENSE NO. DENTIST PHONE NO.	IF PROSTHESIS IS THIS A REPLACEMENT?			REASON FOR REPLACEMENT / DATE OF PRIOR PLACEMENT
FIRST VISIT DATE CURRANT SERIES / PLACE OF TREATMENT OFFICE HOSP ECF OTHER / RADIOGRAPHY OR MODELS ENCLOSED? NO YES HOW MANY?	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

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 HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

______________________________ ______________________________
SIGNED (DENTIST) • DATE

TOTALS	
DEDUCTIBLE	
BALANCE	
CO. INSURANCE	
BENEFIT	

MAIL COMPLETED FORM TO:
PLAN ADMINISTRATOR FITZHARRIS & CO. INC.
PO BOX 9182, FARMINGDALE, NY 11735
TEL. (516) 777-2244 1-800-321-1336

DO NOT COMPLETE THIS SECTION

• MUST BE FURNISHED UNDER AUTHORITY OF LAW

DATE OF EMPLOYMENT ______________ EFFECTIVE DATE (DEPENDENT) ______________
EFFECTIVE DATE (EMPLOYEE) ______________ TERMINATION OF EMPLOYMENT ______________
DATE ______________ SIGNATURE ______________