IMPORTANT NOTICE
PRE-AUTHORIZATION REQUIRED

FOR $500 OR MORE

X-RAYS MUST BE ATTACHED IF CLAIM IS $500 OR MORE

SEE INSTRUCTIONS ON REVERSE SIDE

DENTAL CLAIM FORM
RETURN THIS FORM TO:

East Williston Teachers Association Benefit Fund

253 West 35th Street, 12th Floor
New York, New York 10001-1907
(212) 505-5050 • (800) 342-6651

PATIENT NAME: (print last name first)	SEX ☐ M ☐ F	RELATIONSHIP TO MEMBER ☐ Self ☐ Child ☐ Spouse ☐ Other	PATIENT S.S. #	PATIENT DAT E OF BIRTH MO. DY. YR.
MEMBER NAME: (print last name first)	SEX ☐ M ☐ F	MEMBER S.S. # | |	MEMBER DATE OF BIRTH MO. DY. YR.	BARGAINING UNIT ☐ Act. ☐ Ret. ☐ FT ☐ PT ☐ FA ☐ Guild ☐ Other

HOME ADDRESS: Number and Street	APT.	HOME PHONE (include area code)
CITY	STATE ZIP	WORK 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 #

ARE DENTAL BENEFITS AVAILABLE FROM ANY OTHER CARRIER FOR THIS PATIENT? ☐ YES ☐ NO — IF "YES" GIVE NAME OF CARRIER AND I.D. OF SUBSCRIBER

IF YES, SPOUSE BIRTH DATE _____ MONTH _____ DAY

To be signed, if Benefits are to be paid directly to your doctor.
ASSIGNMENT OF BENEFITS:
I hereby assign to Dr. _____ the benefits I am entitled to as represented by this claim. I understand that I Am financially responsible for charges not covered and/or paid by this assignment.

Date _____ Member's Signature

MEMBER CERTIFICATION:

I certify that the information given is correct and authorize release of any information necessary to process this claim.

Member Sign Here _____ *Date*

DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?			
CITY, STATE, ZIP	ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SOC. SEC. or T.I.N. DENTIST LICENSE NO. DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR EMPLOYMENT
FIRST VISIT DATE CURRENT SERIES — PLACE OF TREATMENT Office Hosp. ECF Other — RADIOGRAPHICS OR MODELS — YES NO — HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

USE CHARTING SYSTEM AT LEFT. DESCRIBE YOUR 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	OFF. USE

– CHECK ONE ONLY –

TOTAL FEE CHARGED

☐ DENTIST'S TREATMENT PLAN (PRE-DETERMINATION)
I hereby certify that the above procedures are necessary to be performed

Dentist's 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

I am a specialist in:
☐ Orthodontics ☐ Periodontics
☐ Endodontics ☐ Other
☐ Oral Surgery

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

R

NOTICE TO MEMBERS

- PRE-DETERMINATION BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST CHARGES AMOUNT TO $500 OR MORE. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-DETERMINATION. Pre-Determination by the Fund's Dental Consultant is limited to the approval of the course of treatment proposed; it does not include approval of payment for services not covered under the Dental Plan, the patient's eligibility, or guaranteed payment. Completed treatment amount to $1,000 or more may require examination of patient by Fund's Dental Consultant before payment is made.

- **CLAIM MUST BE SUBMITTED WITHIN ONE YEAR AFTER COMPLETION OF DENTAL TREATMENT.**

- Bring 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 any questions about your dental benefits, contact the Dental Program Administrator.

- A covered patient may go to any dentist, anywhere, and the amount of payment is the same regardless of the dentist chosen.

- Please make sure you have signed the dental procedure certification box on the bottom of the claim form.

- Mail this form to:
  c/o Daniel H. Cook Associates, Inc.
  253 West 35th Street, 12th Floor
  New York, NY 10001

  East Williston Teachers Association

  Telephone: (212) 505-5050 (800) 342-6651

- Active member and retiree benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees.

  DEPENDENT STUDENT COVERAGE: An unmarried child who is a full time student will be covered up to age 25 (12 hours enrolled for undergraduate credits or 6 hours graduate credits). Proof of student status must be submitted to the Fund before a claim can be honored. Such proof consists of completion of EWTA Benefit Fund Student Verification Form or a letter from the college or university attesting to his/her full time attendance during the period that dental services were performed. If this proof has already been recorded with the Fund, it is not necessary to resubmit it with this claim.

NOTICE TO DENTISTS

- Please note that copies of signatures and "signature on file" will not be accepted by the Fund Office and the claim form will be returned to you. **There is no assignment of benefits under this dental program unless you are a participating provider.**

- Pre-Determination must be filed no later than 30 days after examination.

- If services are for emergency treatment or due to an accidental injury, Pre-Determination will not be necessary.

- PRE-DETERMINATION BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST CHARGES WILL AMOUNT TO $500 OR MORE. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-DETERMINATION. Pre-Determination by the Fund's Dental Consultant is limited to the approval of the course of treatment proposed; it does not include approval of payment for services not covered under the Dental Plan, the patient's eligibility, or guaranteed payment. Completed treatment amount to $1,000 or more may require examination of patient by Fund's Dental Consultant before payment is made.

- All procedures must be corresponding CDT/ADA procedure codes listed in order to be processed.

FUND DENTAL CONSULTANT REMARKS:

ANYONE INTENTIONALLY MISUSING THIS FORM FOR THE PURPOSE OF OBTAINING IMPROPER PAYMENTS IS SUBJECT TO APPROPRIATE ACTION