BENEFIT CLAIM FORM

United Staff Association Welfare Fund

1040 Sixth Ave, 24th Floor
New York, NY 10018
(914) 250-0700

Dental Claim Form

☐ Dentist's pre-treatment estimate — Specialty (see backside)
☐ Dentist's statement of actual services
☐ Medicaid Claim — Prior Authorization #
☐ EPSDT

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 / EMPLOYEE

Subs./Emp ID#/SSN# | Employer Name | Group #

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 POLICIES

Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical | Policy #

Other Subscriber's Name

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

Employer/School Name________ Address________

Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

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 prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No | If no, reason for replacement: | Date of prior placement: | If service already commenced: Date appliances placed | Total mos. of treatment remaining ____

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

THIS FORM WILL BE RETURNED IF IT IS INCOMPLETE OR INCORRECT

NOTICE TO MEMBERS

- PRE-AUTHORIZATION BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST CHARGES WILL AMOUNT TO $600 OR MORE. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-AUTHORIZATION. Pre-authorization 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.

- CLAIM MUST BE SUBMITTED WITHIN 180 DAYS AFTER COMPLETION OF COURSE 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.

NOTICE TO DENTISTS

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

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

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

FUND DENTAL CONSULTANT REMARKS:

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