Dental Claim Form

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

MAIL COMPLETED FORM TO:

LOCAL 891 IUOE Welfare Fund Dental Program
c/o Daniel H. Cook Associates
1040 Avenue of the Americas -24th Floor
New York, NY 10018-3726
(212) 505-5050

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 service already commenced:

If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: — Date of prior placement: — 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	Total Fee
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	Payment by other plan

Remarks for unusual services	
	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 HAVE TO 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 $750 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 1 YEAR AFTER THE END OF THE YEAR IN WHICH THE WORK WAS PERFORMED.
- 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.
- Mail this form to:

  Local 891 IUOE Welfare Fund Dental Program
  c/o Daniel H. Cook Associates
  1040 Avenue of the Americas 24th Floor
  New York, NY 10018 -3726   Telephone (212) 505-5050

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.
- **PRE-AUTHORIZATION 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-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 patients eligibility or guaranteed payment .

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.