Dental Claim Form

☐ Dentist's pre-treatment estimate Specialty (see backside)
☐ Dentist's statement of actual services

Electronic Submission Payer ID: DHCDN
Pre-Authorization $500 Required

MAIL COMPLETED FORM TO:

Yonkers Federation of Teachers
Welfare Fund Dental Benefit
c/o Daniel H. Cook Associates
1040 Avenue of the Americas, 24th FL
New York, NY 10018
914-250-0700

PATIENT

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

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

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	Sex
/ /	☐Married ☐Single ☐Other	☐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	Plan/Program Name
/ /	☐M ☐F	

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?	Is treatment for orthodontics? ☐Yes ☐No
			☐Yes, How many?_____ ☐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
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

YONKERS FEDERATION OF TEACHERS WELFARE FUND DENTAL BENEFIT

c/o Daniel H. Cook Associates

1040 Avenue of the Americas, 24th FL, New York, NY 10018

This Form Will Have to Be Returned if it is incomplete or Incorrect

NOTICE TO MEMBERS

Per-Treatment Authorization Required for $500 or More

ANY PROPOSED DENTAL TREATMENT PROGRAM WITH DENTIST'S CHARGES OF $500 PER COURSE OF TREATMENT OR MORE (DENTIST'S ACTUAL CHARGES) MUST BE CERTIFIED BY THE WELFARE FUND'S DENTAL CONSULTANT BEFORE THE TREATMENT IS BEGUN. X-RAYS MUST BE INCLUDED IF THE CLAIM IS $500 PER COURSE OF TREATMENT OR MORE. A claim submitted for pre-treatment authorization will be returned to the dentist indicating the pre-treatment authorization decision. The pre-treatment authorization will be sent simultaneously to you arid to the dentist. **Work related to this claim, which was submitted for Pre-Treatment Authorization, must be completed within one year from the date of approval.**

- **CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS AFTER COMPLETION OF DENTAL SERVICES.**
- **Claim forms are available at the Fund Office.**
- **TAKE 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 questions about benefits contact the Welfare Fund office or the Fund's Dental Consultant at (914) 250-0700.**
- **Claims may be mailed to the Welfare Fund's office or Electronically submitted with PAYER ID: DHCDN**
- **A COVERED PATIENT MAY GO TO ANY DENTIST, ANYWHERE, AND THE AMOUNT OF PAYMENT IS THE SAME REGARDLESS OF DENTIST CHOSEN.**
- **Mail your claim form to: Yonkers Federation of Teachers Welfare Fund at the address noted above.**

NOTICE TO DENTISTS

Complete all required statements, itemize all proposed services and fees, include X-rays and return form to the Welfare Fund at the address noted above. You will be advised if proposed procedures have been approved. Pre-treatment authorization means that the services are warranted, but Is not a guarantee of payment. Benefits are payable as long as patient remains eligible for this dental coverage on the date treatment is rendered.

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

If services rendered are for emergency treatment, due to an accidental injury, Authorization will not be required.

INSTRUCTIONS FOR SERVICES LESS THAN $500

- **If the estimated charges will be less than $500, Pre-Treatment Authorization is not required.**

INSTRUCTIONS TO DENTIST

Complete all required statements, including present condition, description of services and dates performed- Return completed form to member or the Fund office.

INSTRUCTIONS TO MEMBER

When treatment has been completed, your dentist will return claim form to you. At this time complete the employee section, sign, and send the claim form to the Fund office at the address noted at the top of the page.

IMPORTANT NOTICE!

Any person who knowingly and with the intent to defraud or deceive the Welfare Fund files an application for coverage or statement of claim containing any false or misleading information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime.