DENTAL CLAIM FORM

TO BE COMPLETED BY FUND OFFICE

Member eligible on ________________

Dependent eligible on ______________

By __________ **On** ______________

MAIL TO: **Dental Plan**
Pennsylvania Faculty Health & Welfare Fund
P.O. box 60430
Harrisburg, Pennsylvania 17106-0430
Telephone: (717) 233-4776

PART I – TO BE COMPLETE BY EMPLOYEE/MEMBER

PARTS I & II must be completed in full

1. Patient Name	2. Relationship to employee: Self / Spouse / Child / Other	3. Sex: M / F	4. Patient Birthdate: Mo. / Day / Year	5. Full time student: School / City

6. Member Name: First / Middle / Last	7. Employee/Member Social Security No.	Sex: M / F	Date of Birth: Mo. / Day / Year
8. Employee/Member Mailing Address	**9. Spouses Social Security No.**	**Sex: M / F**	**Date of Birth: Mo. / Day / Year**

10. City, State, Zip

11. Are other family members employed? ❑ Yes ❑ No
If yes,
Employee Name Soc. Sec. #

12. Name and Address of Employer in Item 11.

13. Is patient covered by another Dental Plan? ❑ Yes ❑ No — If yes, Dental Plan name — Union Local — Group No. — Name and Address of Carrier

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any vision plan, vision provider, insurance company, employer or insuring organization to release any information regarding the medical or dental history, treatment or benefits payable for this claim for the purpose of validating and determining benefits payable in connection with this claim. This authorization or photostatic copy of the original shall be valid for one year from the date of signature.
I understand that data may be extracted and transmitted to the Plan Administrator for statistical, audit, and verification purposes.

X________________________________ ____________
Sign here for check to go to the member DATE

AUTHORIZATION TO PAYBENEFITS TO DENTIST– I hereby certify to the above statements.
I hereby authorize payments directly to the below named Dentist to the Group Benefits otherwise payable to me.

X________________________________ ____________
Sign here for check to go to the dentist DATE

PART II – TO BE COMPLETE BY ATTENDING DENTIST

14. Dentist Name

15. Mailing Address

City, State, Zip

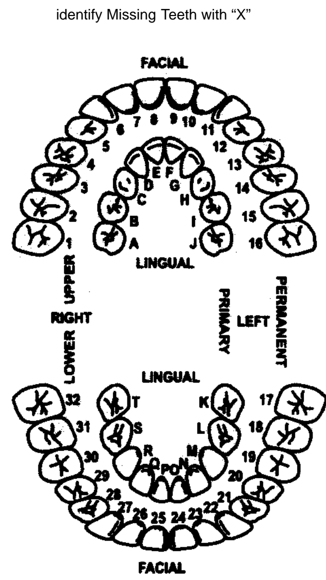
16. Dentist Soc. Sec. or T.I.N. — Dentist License No. — Dentist Phone No.

17. First visit date current series — 18. Place of treatment: Office / Hosp / EFC / Other — 19. Radiographs or Models enclosed: No / Yes / How many?

	No	Yes	
20. Is treatment result of occupational illness or injury?			If yes, enter brief description and dates
21. Is treatment result of auto accident?			
22. Other accident?			
23. Are these services covered by another plan?			If yes, name of other plan
24. If Prosthesis, is this initial placement?			If no, reason for placement — Date of prior placement
25. is treatment for Orthodontics?			If services already commenced enter date appliance placed — mos. treatment remaining

CHECK ONE: ❒ DENTIST'S PRETREATMENT ESTIMATE ❒ DENTIST'S STATEMENT OF ACTUAL SERVICES

identify Missing Teeth with "X"



26. Examination and treatment plan-list in order from tooth No. 1 through tooth No. 32 – Use charting shown.

Tooth # or Letter	Surface (I.s.) M.O.D. B.L.LA.I)	Description of Service (including X-rays, prophylaxis, materials used, etc.)	Date service Performed Mo.	Day	year	Procedure Number	FEE	For Fund Use Only see reverse for Reasonable	REASON CODE
					TOTALFEE CHARGED			

I hereby certify that the procedures as indicated by date have been completed

26. ____ Date ____________

SIGNED(Dentist)

Note: Pretreatment Review is not a guarantee of benefits payable. Failure to seek a Pretreatment review may result in a denial of benefits.

Maximum Allowable

REV. 3/00

Review back of this form for important instructions.

IMPORTANT
READ BEFORE OBTAINING DENTAL SERVICES

THE DETAILED EXPLANATION OF BENEFITS IS REQUIRED FOR PROCESSING

Carefully review your Benefits Booklet prior to obtaining dental services for the following important instructions and explanations.

1. How to complete the Fund's dental benefit claim form.
2. Who is eligible to receive dental benefits.
3. Procedures necessary to comply with pre-treatment review of dental services in excess of $300.00
4. Limitations of the Dental Plan.
5, Schedule of Dental Services – Maximum Allowances
6. Pay careful attention to the coordination of benefits rules – failure to comply with theses provisions may mean delay in processing your dental claims or suspension of benefits.

DENTAL CLAIM FORMS NOT COMPLETED IN FULL OR NOT COMPLETED PROPERLY WILL NOT BE PROCESSED

Fund members may obtain additional dental claim forms by writing to the Fund Office:

Dental Plan
Pennsylvania Faculty Health & Welfare Fund
P.O. Box 60430
Harrisburg, Pennsylvania 17106-0430