DENTAL CLAIM FORM

PLEASE PRINT ALL INFORMATION BELOW CLEARLY FOR PROMPT PROCESSING OF YOUR CLAIM.

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 COMPLETED BY MEMBER/EMPLOYEE

PARTS I & II must be completed in full

1. Employee Name (First, Middle, Last)		2. Member Date of Birth Mo. | Day | Year	3. Sex M | F	4. University where member is employed.
5. Patient Name	6. Relationship to Employee Self | Spouse | Child | Other	7. Patient Date of Birth Mo. | Day | Year	8. Sex M | F	9. Full time Student School: City:
10. Employee Mailing Address		11. Spouse Date of Birth Mo. | Day | Year	12. Sex M | F	13. Company where Spouse is employed.
14. City, State, Zip		15. Member Telephone Number:		
16. Is patient covered by another Dental Plan? ❑ Yes ❑ No If yes, Dental Plan name		17. Name and Address of Insurance Carrier		

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any dental plan, dental 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 PAY BENEFITS 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 _____

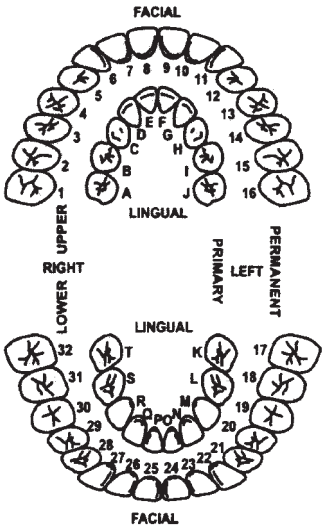
PART II – TO BE COMPLETED BY ATTENDING DENTIST

18. Dentist Name		24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates	
19. Mailing Address		25. Is treatment result of auto accident? 26. Other accident?				
City, State, Zip		27. Are these services covered by another plan?			If yes, name of other plan	
20. Dentist Soc. Sec. or T.I.N. Dentist License No. Dentist Phone No.		28. If Prosthesis, is this initial placement?			If no, reason for placement	Date of prior placement
21. First visit date current series	22. Place of treatment Office | Hosp | EFC | Other; 23. Radiographs or Models enclosed No | Yes How many?	29. 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

For Fund Use Only

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
						TOTAL FEE 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.

REV. 7/06