DOBBS FERRY UNITED TEACHERS WELFARE FUND

THIS FORM WILL HAVE TO BE RETURNED IF IT IS INCOMPLETE OR INCORRECT

NOTICE TO MEMBERS

- CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS AFTER COMPLETION OF DENTAL SERVICES.
- Claim forms are available at the Welfare 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
- A covered patient may go to any dentist, anywhere, and the amount of payment is the same regardless of the dentist chosen.
- **IF YOU HAVE QUESTIONS ABOUT BENEFITS CONTACT 212-505-5050**
- If claim is for dependent student over age 19, attach proof of school attendance.

- Mail this form to: DOBBS FERRY UNITED TEACHERS
  WELFARE FUND
  253 West 35th Street, 12th Floor
  New York, NY 10001-1907

INSTRUCTIONS TO DENTIST

Complete all required statements, including present condition, description of services and dates performed. (Post-Treatment X-rays, if performed, must accompany claims for root canal treatment and crowns). Return completed form to member or the Welfare Fund Office.

INSTRUCTIONS TO MEMBER

When treatment has been completed, your Dentist will return claim form to you. At this time, complete the employee portion, sign, and send form to the Welfare Fund Office.

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:
DOBBS FERRY UNITED TEACHERS WELFARE FUND
253 West 35th Street, 12th Floor
New York, NY 10001-1907

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:
Date appliances placed _____ Total mos. of treatment remaining _____

If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No | If no, reason for replacement: | Date of prior placement:

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

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

Remarks for unusual services

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