Dental Claim Form

Dentist's pretreatment estimate Specialty (see backside) Dentist's statement of actual services						
Medicaid Claim EPSDT	Prior Authorization #					

MAIL COMPLETED FORM TO:

Dobbs Ferry United Teachers c/o Daniel H. Cook Associates

1040 Avenue of the Americas – 24th Fl New York, NY 10018-3726 (914) 250-0700

Γ	Patient Name (Last, First, Middle)				Address	Address				City	City			State
PATIENT	Date of Birth (MM/DD/YYYY) Patient ID #					Sex		Phone I	Vumber	r		Zip Code		
	Relationship to Subscriber/Employee:							Employ Name	er/School		Address			
	Subs./Emp. ID#/SSN#	Emplo	yer Name		Gr	oup#	T	102222-000-00-00-00-00-00-00-00-00-00-00-		by another plan	AND PARTY OF THE PARTY OF		Polic	;y #
SUBSCRIBER / EMPLOYEE	Subscriber/Employee	***************************************	OTHER POLICIES	□No (Skip Other S	32–37) ubscriber	☐Yes: ☐Dent s Name	al or 🗆 Med	ıcal						
	Address . (Phone Number			Birth (MM/	DDYYYY)	Sex			am Name
	City State				Zip Code	Zip Code O			/					
RIBE	Date of Birth (MM/DD/YYYY) Marital Status / / / □ Married □ Single □ Ot				Other	Sex			Subscriber/Employee Status					
UBSC	I have been informed charges for dental service	of the treatment pl	an and associate	ed fees 1	agree to be rest	onsible for			□Employed □Part-time Status □Full-time Student □Part-time Student Employer/School					
8	charges for dental services and materials not paid by my dental benefit plan, unless th dentist or dental practice has a contractual agreement with my plan prohibiting all or a charges. To the extent permitted under applicable law, I authorize release of any infort to this claim.					portion of	such iting	Name Address I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.					directly to the	
	XSigned (Patient/Guardian)					****		x						
-	Name of Billing Dentis			Uate (MM/DD/YYYY)			Signed (Em	ployee/su			Date (MM/DD/		
	Name of blining Denks	t or Dental Entity				(Phor	ne Numi)	ber	0.000	Provider ID#		Dentist S	oc. Sec. or	T.I.N.
BILLING DENTIST	Address					Dent	ist Licer	nse #	First visit date of current series;		rrent		Place of treatment Office □ Hosp. □ ECF □ Other	
	City State Zip Code					Radiographs or models encl					is treatm	ent for orthodo		
ING I	If amethesis (crown b	ridon donluses))	16 - 16			☐Yes, How many? ☐No				If service already commenced:				
BILL	If prosthesis (crown, bridge, dentures), is this If no, reason for replacement: initial placement? ☐Yes ☐No						Date of prior placement.						Total mos	s. of treatment
	Is treatment result of occupational illness or injury? ☐No ☐ Yes Brief description and dates						Is treatment result of; □auto accident? □other accident? □neither							
	Diei descripiteit Bild date					Brief des	cripuon	and dates						
1	lagnosis Code Index (option 2.	al) 3	l	4.		5			6	7.		8.		
	xamination and treatment pl	· · · · · · · · · · · · · · · · · · ·	·				γ						Adm	in. Use Only
Date	Tooth Tooth	Surface	Diagnosis In	idex #	Procedure Cod	te Oty	 		Descri	ption		Fee		
							1							i
												**		
		ļ												
\dashv		-					 							
	- - 	 				_	┼							
		1	1	-+			 						1	
ld	entify all missing teeth with		1						Tra	otal Fee			1	!
Permanent 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 A I						rimary				lyment by other pla				1
32			23 22 21 2	20 19 11	B 17 T	SRQ	Р	0 N M L	K Ma	ax. Allowable				1
Remarks for unusual services Deductible														
	Carrier %													
Carrier pays Patient pays														
11	nereby certify that the proces	fures as indicated	by date are in a	rogress (f	or procedures to	hat require	mulliole	visits) or	Add	ess where treatme	nt was perfer	med		
have proce	been completed and that the	fures as indicated fees submitted a	by date are in pre the actual fee	progress (f	or procedures the charged and inte	hat require and to colle	multiple ct for th	visits) or ose		ess where treatme	nt was perfor			
proce	been completed and that the	rees submitted a	by date are in pre the actual fee	progress (f es have c	or procedures to the procedures to the procedures to the procedures to the procedure to the procedures to the procedure to the	end to colle	multiple at for the	e visits) or ose	Addr	ess where treatme	nt was perfor		tate	Zip Code

THIS FORM WILL 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 \$1,000 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 ELIGIBLITY OR GUARANTEED PAYMENT.
- CLAIM MUST BE SUBMITTED WITHIN 1 YEAR AFTER COMPLETEION OF COURSE OF DENTAL TREATMENT.
- Bring a claim form with you when you visit your dentist. Complete your part give all the information required. DISCUSS FEES BEFORE SERVICES ARE PREFORMED. 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: **Dobbs Ferry United Teachers**

c/o Daniel H. Cook Associates

1040 Avenue of the Americas – 24^{th} Floor

New York, NY 10018-3726 Telephone (914) 250-0700

NOTICE TO DENTIST

- 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 \$1,000 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 ELIGIBLITY OR GUARANTEED PAYMENT.
- All Procedures must have corresponding CDT/ADA procedure codes listed in order to be processed.

FUND DENTAL CONSULTANT REMARKS:	
	_
	_
	_
	_
	_

ANYONE INTENTIONALLY MISSING THIS FORM FOR THE PURPOSE OF OBTAINING IMPROPER PAYMENTS IS SUBJECT TO APPROPRIATE ACTION.