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

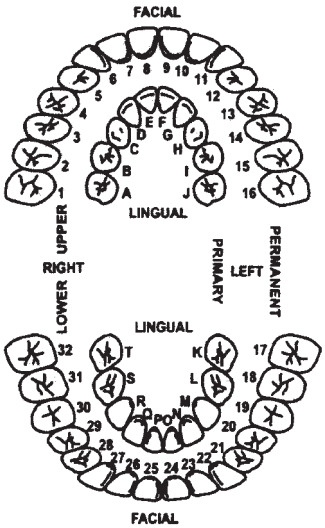
18. Dentist Name
19. Mailing Address
City, State, Zip
20. Dentist Soc. Sec. or T.I.N. Dentist License No. Dentist Phone No.
21. First visit date current series
22. Place of treatment Office | Hosp | EFC | Other
23. Radiographs or Models enclosed No | Yes How many?

	No	Yes	
24. Is treatment result of occupational illness or injury?			If yes, enter brief description and dates
25. Is treatment result of auto accident?			
26. Other accident?			
27. Are these services covered by another plan?			If yes, name of other plan
28. If Prosthesis, is this initial placement?			If no, reason for placement / Date of prior placement
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	For Fund Use Only