



**IMPORTANT NOTICE**  
PRE-AUTHORIZATION REQUIRED  
FOR \$500 OR MORE

**X-RAYS MUST BE ATTACHED IF  
CLAIM IS \$500 OR MORE**

SEE INSTRUCTIONS ON REVERSE SIDE

A  
C  
T  
I  
V  
E

**DENTAL CLAIM FORM - DO NOT DETACH**

RETURN THIS FORM TO  
Local 891 IUOE Welfare Fund Dental Program  
253 W 35th St. 12 Floor  
New York, New York 10001  
(212) 505-5050

M  
E  
M  
B  
E  
R

PATIENT NAME: (print last name first)		SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO MEMBER <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	PATIENT DATE OF BIRTH MO. DY. YR.
MEMBER NAME: (print last name first)		SEX <input type="checkbox"/> M <input type="checkbox"/> F	MEMBER'S SOCIAL SECURITY NUMBER	MEMBER DATE OF BIRTH MO. DY. YR.
HOME ADDRESS: Number and Street		APT.		HOME PHONE (include area code)
CITY	STATE	ZIP	PAYROLL TITLE	EMPLOYER PHONE (include area code)
IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER AND SPOUSE'S SOCIAL SECURITY #				
ARE DENTAL BENEFITS AVAILABLE FROM ANY OTHER CARRIER FOR THIS PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SPOUSE BIRTHDATE _____ MONTH _____ DAY				
I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. BENEFITS ARE NOT AVAILABLE UNDER ANY OTHER GROUP PLAN EXCEPT AS INDICATED ABOVE.		I hereby authorize and request the Local 891 IUOE Welfare Fund Dental Program to pay the amount otherwise due and payable to me to the undersigned dentist. I understand that I am financially responsible for charges not covered and/or paid by this assignment, and that this payment method is being used for my convenience and does not constitute an obligation of the Fund.		
Member Sign Here _____ Date _____		ASSIGNMENT OF BENEFITS Member's Signature _____ Date _____		

D  
E  
N  
T  
I  
S  
T

DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?			
CITY, STATE, ZIP	ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SOC SEC. or T.I.N. DENTIST LICENSE NO. DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR EMPLOYMENT
FIRST VISIT DATE PLACE OF TREATMENT RADIOGRAPHICS OR MODELS YES NO HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

<p>Indicate missing teeth with 'X'</p> <p>REMARKS FOR UNUSUAL SERVICES ON ATTACHMENT CHECK <input type="checkbox"/></p>	<b>USE CHARTING SYSTEM AT LEFT. DESCRIBE YOUR TREATMENT PLAN OR SERVICES COMPLETED.</b>						OFF-USE		
	Tooth or Letter	Sur-face	DESCRIPTION OF SERVICE (including X-RAYS, PROPHYLAXIS, MATERIALS USED, etc.) LINE NO.	Date Service Performed	CDT Procedure Number	FEE			

M  
E  
M  
B  
E  
R

— CHECK ONE ONLY —

<input type="checkbox"/> DENTIST'S TREATMENT PLAN (PRE-AUTHORIZATION): I hereby certify that the above procedures are necessary to be performed. _____ Dentist's Signature Date	<input type="checkbox"/> DENTIST'S STATEMENT OF ACTUAL SERVICES: I hereby certify that the above procedures were rendered on the dates indicated. _____ Dentist's Signature Date	<b>TOTAL FEE CHARGED</b>  I am a specialist in: <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Orthodontics <input type="checkbox"/> Periodontics <input type="checkbox"/> Endodontics <input type="checkbox"/> Other
--	---	---

I certify that to the best of my knowledge the dental procedures listed above were actually performed and the dates on which they were performed are accurate. Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE NOTE THAT THIS MUST BE SIGNED BY THE MEMBER/PATIENT IN ORDER FOR THIS CLAIM TO BE PROCESSED.**

## 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 \$500 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 eligibility or guaranteed payment. Complete treatment amounting to \$1,000 or more may require examination of patient by Fund's Consultant Dentist before payment is made.
- CLAIM MUST BE SUBMITTED WITHIN 1 YEAR AFTER THE END OF THE YEAR IN WHICH THE WORK WAS PERFORMED.
- Bring a claim form with you when you visit your dentist. Complete your part - give all the information required. **DISCUSS FEES BEFORE SERVICES ARE PERFORMED.** 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.
- Please make sure you have signed the dental procedure certification box on the bottom of the claim form.
- Mail this form to: **Local 891 IUOE Welfare Fund Dental Program**  
**200 Park Avenue South - Suite 1200**  
**New York, New York 10003-1599** Telephone: (212) 505-5050

## NOTICE TO DENTISTS

- Please note that copies of signatures and "signatures on file" will not be accepted by the Fund office and the claim form will be returned to you
- 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 \$500 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 eligibility or guaranteed payment. Complete treatment amounting to \$1,000 or more may require examination of patient by Fund's Consultant Dentist before payment is made.

FUND DENTAL CONSULTANT REMARKS:

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

