HARRISON TEACHER'S BENEFITS TRUST

c/o Preferred Group Plans
P.O. Box 15136, Albany, New York, NY 12212-5136
(800) 573-7474

DENTAL CLAIM FORM (this section to be completed by employee) GROUP # 7900

1. Employee Name			2. Social Security No.	
3. Employee's Mailing Address				
4. Patient Name (if a dependent)	5. Relationship to Employee		6. Birth Date	7. Tel. No.
8. Does Patient have other health coverage? Yes[ ] No[ ] If yes, please identify				

TO BE COMPLETED BY DENTIST

IF CLAIM IS BASED ON ACCIDENT:

WHEN DID ACCIDENT OCCUR? DATE _______ TIME ______

WHERE DID ACCIDENT OCCUR? ____________________

HOW DID IT HAPPEN? ______________________________

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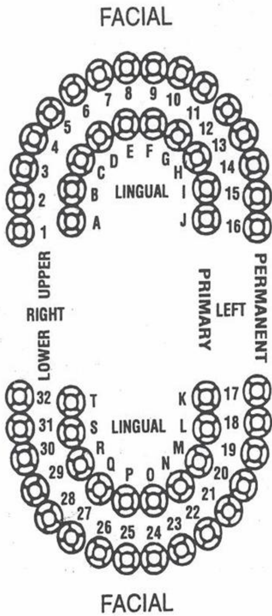
CHECK ONE: [ ] DENTIST'S PRE-STATEMENT ESTIMATE
[ ] DENTIST'S STATEMENT OF ACTUAL SERVICE

If Charges will be for $500.00 or more, this form must be submitted for pre-determination of benefits. After review by the Fund Office, the member and the dentist will be notified of the estimated payment.

Dentist's Name (Print)	Telephone No.	Individual Practitioner's – SS No.	
Address City State or Province Zip		All Others – Employer I.D. No.	

Is any of the treatment for Orthodontic purposes [ ] YES [ ] NO	IF PROSTHEISS, IS THIS INITIAL PLACEMENT? [ ]YES [ ]NO IF NO, REASON FOR PLACEMENT:	DATE OF PRIOR PLACEMENT:
X-Rays are required for extraction of impacted teeth, gold restorations, crowns or bridge work and may also be requested for other services. X-Rays will be returned to Dentist promptly.		Are X-Rays enclosed? [ ] YES [ ]NO If YES, How Many?



EXAMINATIONS AND TREATMENT RECORD – USE CHARTING SYSTEM SHOWN

TOOTH No. OR LETTER	NAME OF SURFACES ABBR.	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	ADA PROCEDURE NUMBER	DATE SERVICE PERFORMED MO	DA	YR	FEE	FOR CARRIER USE ONLY
				TOTAL FEE ACTUALLY CHARGED				

Indicate missing teeth with an "X"
Remarks for unusual services

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM:

____

DATE: ____________________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: **I hereby authorize payment directly to the above physician for vision benefits otherwise payable to me for his services described on this form, but not to exceed the reasonable IGNED (Patient or Parent if minor) and customary fee for the service.**

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I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED: _________________________________ DATE: __________
Signature of Dentist