DENTAL CLAIM FORM

MAMARONECK TEACHERS ASSOCIATION WELFARE FUND

c/o Insurance Programmers, Inc.
60 North Main Street • P.O. Box 5817
Wallingford, CT 06492-7617
Tel.: 1-888-949-6342 or 1-800-827-1703

EMPLOYEE COMPLETE SHADED SECTIONS

1. EMPLOYEE'S NAME	2. SOCIAL SECURITY NO	3. EMPLOYEE'S BIRTHDATE
4. EMPLOYEE'S MAILING ADDRESS (City) (State) (Zip)		5. TEL. NO.
6. PATIENT'S NAME (IF A DEPENDENT)	7. RELATIONSHIP to EMPLOYEE	8. PATIENT'S BIRTHDATE / 9. DATE FIRST VISIT (Current Series)
10. PATIENT'S SOCIAL SECURITY NO.	11. DOES PATIENT HAVE OTHER DENTAL 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? _____

_____

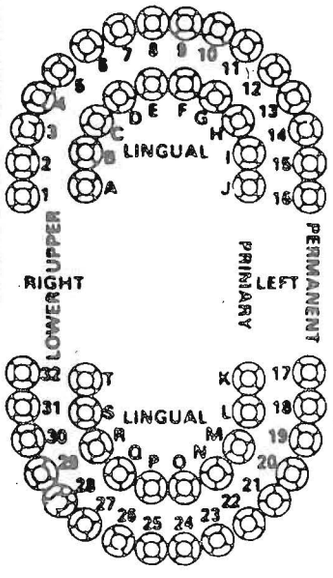
CHECK ONE: ☐ DENTIST'S PRE-STATEMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICE

If charges will be for $300.00 or more, this form must be submitted for pre-determination of benefits. After review by the Claims Office, the member and the dentist will be notified of the estimated payment.

DENTIST'S NAME (Print)	TELEPHONE NO.	Individual Practitioners - SS No. / All Others - Employer I.D. No.
ADDRESS CITY STATE OR PROVINCE ZIP		LICENSE NO. (Must be furnished under authority of law)

IS ANY OF THE TREATMENT FOR: ORTHODONTIC PURPOSES ☐ YES ☐ NO	IF PROSTHESIS, IS THIS INITIAL PLACEMENT? YES ☐ NO ☐ IF NO, REASON FOR REPLACEMENT:	DATE OF PRIOR PLACEMENT: MO DA. YR.
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 the Dentist promptly.		ARE X-RAYS ENCLOSED? YES ☐ NO ☐ IF YES, HOW MANY?

FACIAL



FACIAL

INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES:

EXAMINATIONS AND TREATMENT RECORD - USE CHARTING SYSTEM SHOWN								FOR CARRIER USE ONLY
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	
				TOTAL FEE ACTUALLY CHARGED				

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

_____

SIGNED (PATIENT, OR PARENT IF MINOR)

DATE _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the above physician for dental benefits otherwise payable to me for his services described on this form, but not to exceed the reasonable and customary fee for the service.

Signed _____

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

SIGNED (DENTIST) _____ DATE _____