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

ORGANIZATION

1. PATIENT NAME:

2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER

3. SEX: M | F

4. PATIENT BIRTHDATE: MO. | DAY | YEAR

5. IF FULL TIME STUDENT: SCHOOL CITY

6. EMPLOYEE/SUBSCRIBER NAME: First Middle Last

7. EMPLOYEE SOC. SEC. NO.

8. EMPLOYER (COMPANY) NAME AND ADDRESS

9. EMPLOYEE/SUBSCRIBER MAILING ADDRESS

CITY, STATE, ZIP

**ELIGIBILITY DATE**

**CARD NUMBER** **APPROVAL DATE**

10. GROUP NO.

11. IS SPOUSE EMPLOYED? ☐ YES ☐ NO
Employee Name Soc. Sec. No. Date of Birth

12. NAME AND ADDRESS OF EMPLOYER IN ITEM 11

13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?
DENTAL PLAN NAME UNION LOCAL GROUP NO. NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

**SIGNED (PATIENT, OR PARENT IF MINOR)** **DATE**

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

**SIGNED (INSURED PERSON)** **DATE**

14. DENTIST NAME DR. CODE

15. MAILING ADDRESS

CITY, STATE, ZIP

16. DENTIST (Soc. Sec. or TIN) 17. DENTIST LIC. NO. 18. DENTIST PHONE NO.

19. Is Treatment Result of Occupational Illness or Injury? NO YES IF YES, ENTER BRIEF DESCRIPTION & DATES

20. Is Treatment Result of Auto Accident?
21. Other Accident?

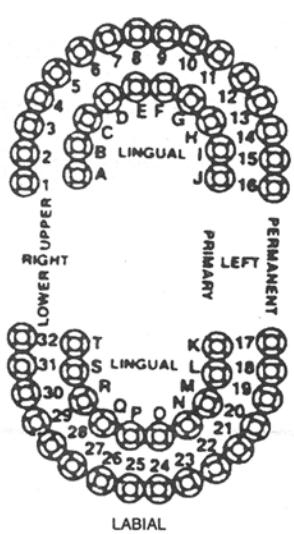
22. Are Any Services Covered by Another Plan?

23. If Prosthetics, is this initial Placement? (If NO, reason for replacement) 25. Date of Prior Placement

**REMARKS FOR UNUSUAL SERVICES**

**D.D.S. INFO**

INDICATE MISSING TEETH WITH AN "X"




EXAMINATION AND TREATMENT RECORD-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

| TOOTH NO. LETTER/ QUAD | SUR-FACES | (INCLUDING X-RAYS, PROPHLAXIS MATERIAL USED, ETC.) | DATE SERVICE PERFORMED MO. | DAY | YR. | ADA PROCEDURE NUMBER | FEE | FOR ADMINIS-TRATIVE USE ONLY | CO-PAY |
|---|---|---|---|---|---|---|---|---|---|
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If the treatment exceeds $300.00 then this form and the patient's x-rays must be sent to the address below for pre-authorization. Pre- and post op x-rays required on all unauthorized root canals

**TOTAL**

Date _____

Previous Utilization _____

Total Fees Covered _____

Patient Pays _____

Approved _____

Approved With Limitation _____

Disapproved _____

Approved By _____

| | |
|---|---|
| PREVIOUS UTILIZATION TO DATE | |
| AMOUNT BILLED ___ YEAR | |
| DEDUCTIBLE | |
| PATIENT PAYS | |

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE OF SERVICES, HAVE BEEN PERFORMED

**SIGNED (Dentist)**

DATE

Benefits will be paid, provided that members insurance is in force at the time services are rendered, and subject to coordination of benefits and remaining maximum at the time of submission for payments.

® GCU 247-C

***REMOVE ALL X-RAYS WHEN SUBMITTING FOR PAYMENT ON AUTHORIZED WORK.***

***MAIL CLAIM FORMS TO: DDS., INC. 1640 HEMPSTEAD TURNPIKE, EAST MEADOW, NY 11554-1040- (516) 794-7700***

PLEASE PRINT & FAX FORM TO (516) 794 - 7762