

DENTAL CLAIM FORM

*Patrolmen's
Benevolent
Association*
Of The City Of New York, Incorporated



NYC PBA FUNDS OFFICE
40 Fulton Street, 2nd Floor New York, N.Y. 10038-1850
212-349-7560

PLEASE PRINT - SEE REVERSE SIDE BEFORE COMPLETION

MEMBER COMPLETES

1. MEMBER'S SOCIAL SECURITY NO. _____ 2. MEMBER'S NAME (LAST, FIRST, MIDDLE INITIAL) _____

3. MEMBER'S ADDRESS (NUMBER, STREET) _____ CITY _____ STATE _____ ZIP CODE _____

4. PATIENT'S FIRST NAME _____ 5. PATIENT'S LAST NAME _____ 6. PATIENT'S RELATIONSHIP TO MEMBER _____ 7. PATIENT'S DATE OF BIRTH _____
Y SELF Y SPOUSE Y DGHTR Y SON Y STEP-CHILD Y OTHER

8. DOES PATIENT HAVE OTHER HEALTH AND/OR DENTAL COVERAGE NO YES. IF YES, PLEASE GIVE THE FOLLOWING:
 POLICY HOLDER'S NAME _____ SOCIAL SECURITY NO. _____
 NAME AND ADDRESS OF EMPLOYER/UNION _____
 NAME OF INSURANCE CARRIER _____

9. **MEMBER'S SIGNATURE** IS REQUIRED ON ALL CLAIM FORMS, SIGNATURE OF SPOUSE OR PHOTOCOPY OF MEMBER'S SIGNATURE IS NOT ACCEPTABLE.
 I HEREBY CERTIFY THAT ALL SERVICES LISTED BELOW WITH A DATE OF SERVICE HAS BEEN DONE AND/OR REQUEST
 PRE-CERTIFICATE FOR TREATMENT PLAN LISTED WITHOUT DATES OF SERVICE.

PLEASE MAKE REIMBURSEMENT PAYABLE TO MEMBER DENTIST _____ SIGNATURE OF MEMBER _____ DATE / / ACTIVE RETIRED

DENTIST COMPLETES

10. DENTIST NAME _____ 13. PHONE NO. () _____ MEMBER'S HOME PHONE () _____

11. DENTIST ADDRESS NUMBER AND STREET _____ 14. PRACTICE GENERAL PERIO ORTHO ENDO ORAL SURGERY PROSTHO PEDOD

12. CITY _____ STATE _____ ZIP CODE _____ DENTIST TAX IDENT. NO. TAX S.S.

DENTIST INDICATE MISSING TEETH WITH AN X	EXAMINATION AND TREATMENT RECORD — USE CHARTING SYSTEM SHOWN						
	TOOTH OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS PROPHYLAXIS, MATERIALS USED ETC.)	DATE SERVICE PERFORMED MO. DAY. YR.	PROCEDURE CODE	FEE	FUND USE ONLY
				/ /			
				/ /			
				/ /			
				/ /			
				/ /			
				/ /			
				/ /			
				/ /			
				/ /			
				/ /			

15. ARE X-RAYS ENCLOSED YES NO
IF YES, HOW MANY? _____

16. IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT YES NO

17. IF NO, REASON FOR REPLACEMENT _____

18. DATE OF PRIOR PLACEMENT _____

19. I CERTIFY THAT THE PROCEDURES INDICATED WILL BE OR HAVE BEEN COMPLETED

SIGNED (DENTIST) _____ DATE _____

TOTAL FEE CHARGE **➔**

TOTAL BENEFIT

C.O.B.

FOR OFFICE USE	EXAM	AUDIT	CODE	X-RAY	DENTIST PROFILE	REMARKS
----------------	------	-------	------	-------	-----------------	---------

INSTRUCTIONS

PRECERTIFICATION IS **REQUIRED** FOR ALL CROWN AND BRIDGE, PROSTHETIC, ORTHODONTIC, AND PERIODONTIC WORK.

DENTIST: X-RAYS MUST BE SUBMITTED WITH ALL CLAIMS REQUESTING PRECERTIFICATION.
STUDY MODELS ARE ALSO REQUIRED FOR ALL ORTHODONTIC CLAIMS.
PERIO CHARTING IS REQUIRED FOR ALL PERIODONTIC CLAIMS

MEMBER: DO NOT ALLOW YOUR DENTIST TO COMMENCE ANY PROCEDURES WHERE PRECERTIFICATION IS REQUIRED UNTIL BOTH YOU AND YOUR DENTIST HAVE RECEIVED THE PRECERTIFICATION. OTHERWISE, YOU WILL BE LIABLE FOR PAYMENT OF SERVICES THAT MIGHT NOT BE APPROVED BY THE PLAN.

NOTE: ALL COMMUNICATIONS WITH THE FUNDS OFFICE MUST INCLUDE PATIENTS CLAIM NUMBER (WHEN KNOWN) OR MEMBERS SOCIAL SECURITY NUMBER.

IMPORTANT: FOR PROTECTION OF YOURSELF AND THE PBA FUNDS, PLEASE DO NOT SIGN BOX #9 ON THE FRONT OF THIS FORM UNTIL THOSE SERVICES ACTUALLY ARE PERFORMED OR THOSE REQUIRING PRECERTIFICATION HAVE BEEN FILLED-IN BY THE DENTIST.

ALL CLAIMS SUBJECT TO REVIEW FOR COORDINATION OF BENEFITS