Dental Claim Form

☐ Dentist's pre-treatment estimate Specialty
☐ Dentist's statement of actual services
☐ Medicaid Claim Prior Authorization #
☐ EPSDT

Mail completed form to

PORT JERVIS TEACHERS' ASSOCIATION
BENEFIT FUND OFFICE
P. O. Box 95
Port Jervis, New York 12771

PATIENT

Patient Name (Last, First, Middle) | Address | City | State

Date of Birth (MM/DD/YYYY) / / | Patient ID # | Sex ☐M ☐F | Phone Number ( ) | Zip Code

Relationship to Subscriber/Employee:
☐ Self ☐ Spouse ☐ Child ☐ Other_____

Employer/School
Name_____ Address_____

SUBSCRIBER / EMPLOYEE

Subs./Emp. ID#/SSN# | Employer Name | Group #

Subscriber/Employee Name (Last, First, Middle)

Address | Phone Number ( )

City | State | Zip Code

Date of Birth (MM/DD/YYYY) / /

Marital Status ☐Married ☐Single ☐Other

Sex ☐M ☐F

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

Is Patient covered by another plan ☐No ☐Yes: ☐Dental or ☐ Medical | Policy #

Other Subscriber's Name

Date of Birth (MM/DD/YYYY) / / | Sex ☐M ☐F | Plan/Program Name

Employer/School
Name_____ Address_____

Subscriber/Employee Status
☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

Employer/School
Name_____ Address_____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

Name of Billing Dentist or Dental Entity | Phone Number ( ) | Provider ID # | Dentist Soc. Sec. or T.I.N.

Address | Dentist License # | First visit date of current series: | Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other

City | State | Zip Code | Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | Is treatment for orthodontics? ☐Yes ☐No

If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No | If no, reason for replacement: | Date of prior placement: | If service already commenced: Date appliances placed | Total mos. of treatment remaining

Is treatment result of occupational illness or injury? ☐No ☐ Yes
Brief description and dates_____

Is treatment result of: ☐auto accident? ☐other accident? ☐neither
Brief description and dates_____

Diagnosis Code Index (optional)
1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8._____

Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

Identify all missing teeth with "X"

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

Address where treatment was performed
City | State | Zip Code

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P. O. Box 95
Port Jervis, New York 12771

Incomplete or inaccurate forms will be returned to the member.

PRE-TREATMENT AUTHORIZATIONS

Pre-treatment authorization is required for any individual procedure with a charge of $800.00* or more, **except** for the following:

root canal therapy;
orthodontic treatment plans;
immediate services of $800.00* or more provided in a **single** visit due to emergencies or accidental injury;
services for which the PJTA Benefit Fund Dental Plan does not provide primary coverage.

Pre-treatment authorization requests must be received at the PJTA Benefit Fund Office within 30 days of the dentist's initial examination. No claim for such procedures will be processed for payment before the PJTA Benefit Fund dental consultant has given authorization.

* = the amount in effect for the 2015-2016 plan year.
Refer to the annual Complete Schedule of Benefits for the amount in effect for subsequent plan years.

The PJTA Benefit Fund claim form or a standard form such as the American Dental Association's form or other computer-generated forms that contain the same information as is required on the PJTA Benefit Fund dental claim form must be used to file for pre-treatment authorization. If any other attending dentist's statement is used to file for pre-treatment authorization, it must be attached to a completed PJTA Benefit Fund claim form. **X-rays must accompany pre-treatment authorization requests.**

Pre-treatment authorization decisions are sent directly to the dentist by the fund's consultant. The fund issues pre-treatment authorizations to indicate that certain procedures are warranted. The authorization also includes a pre-determination of the anticipated benefit payments for certain procedures. This pre-determination may be used by the dentist as a guide in determining the amount of pre-treatment payment that the dentist may require, but the pre-determination is not a guarantee that the amounts listed will be paid by the fund. Benefits can be determined only at the time of claim submission, and no benefit for any procedure is paid prior to the completion of the procedure. Members may refer to the Complete Schedule of Benefits for the plan year for the maximum benefits payable under the Dental Plan.

To avoid delays in processing forms, do not submit incomplete or inaccurate forms, and do not submit a request for pre-treatment authorization on the same form as a claim for completed procedures.

CLAIMS

Claims must be received at the fund office within 90 days of the completion of services.
Post-treatment x-rays must be included with root canal therapy claims.
No benefit for any procedure will be paid prior to the completion of the procedure.
Employee and patient original dated signatures are required unless the use of "Signature on File" is authorized.
To avoid delays in processing, do not submit incomplete or inaccurate forms, and do not submit a claim for completed procedures and a request for pre-treatment authorization together on the same claim form.