Funds Office

Patrolmen's Benevolent Association
of the City of New York
250 Broadway New York, N.Y. 10007

(SEE REVERSE SIDE BEFORE COMPLETION)

CLAIM #

COMPLETES

1 PATIENT'S NAME (LAST FIRST MIDDLE INITIAL)

2 PATIENT'S RELATIONSHIP TO MEMBER
☐ SELF ☐ SPOUSE ☐ DG TR ☐ SON

3 PATIENT'S DATE OF BIRTH

4 IN ORDER TO AVOID A DELAY IN PROCESSING WHEN PATIENT HAS OTHER HEALTH INSURANCE, GIVE:
POLICY HOLDER'S NAME AND SOCIAL SECURITY NO
NAME AND ADDRESS OF EMPLOYER OR UNION
NAME OF INSURANCE CARRIER

5 MEMBER'S SOCIAL SECURITY NO. MEMBER'S

6 NAME (LAST FIRST, MIDDLE INITIAL)

7 MEMBER'S ADDRESS (NUMBER, STREET)
CITY STATE, ZIP CODE

8 I HEREBY CERTIFY THAT ANY PROCEDURES LISTED BELOW WITH ACTUAL DATE SERVICE, HAVE BEEN PERFORMED I ALSO AUTHORIZE PAYMENT DIRECTLY TO
☐ DENTIST ☐ MEMBER
MEMBER S SIGNATURE DATE

9 DENTIST

10 DENTIST ADDRESS (NUMBER

11 STREET) CITY STATE, ZIP CODE

12 DENTIST S IRS IDENT NO (PLEASE (✓)) TAX # ☐ or SS # ☐

13 DENTIST PHONE NO Area Code
( )

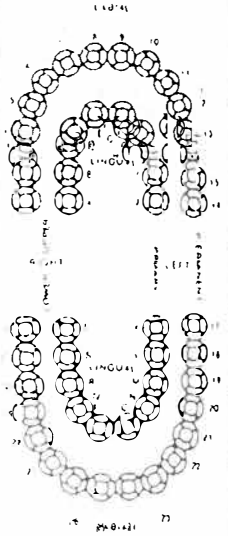
WHEN THIS FORM IS COMPLETED BY YOUR DENTIST AND BY YOU, RETURN IT TO THE FUND OFFICE AT THE ADDRESS SHOWN ABOVE

PRECERTIFICATION IS REQUIRED FOR:

- CROWN AND BRIDGE
- PROSTHETICS
- ORTHODONTICS

SEE OTHER SIDE FOR INSTRUCTIONS

DENTIST
INDICATE MISSING TEETH WITH AN X



14 ARE X RAYS ENCLOSED
☐ YES
☐ NO
IF YES HOW MANY? ___

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	FOR USE

15 IF PROSTHESIS IS THIS THE INITIAL PLACEMENT
☐ YES ☐ NO

16 IF NO REASON FOR REPLACEMENT

17 DATE OF PRIOR PLACEMENT

TOTAL FEE CHARGE

TOTAL BENEFIT

COB

18 I CERTIFY THAT THE PROCEDURES INDICATED WILL BE OR HAVE BEEN COMPLETED
SIGNED (DENTIST) DATE

FOR OFFICE USE	EXAM	AUDIT	CODE	X RAY	DENTIST PROFILE	REMARKS

4 (REV 5 85) (13)

(SEE OTHER SIDE →)