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

ORGANIZATION
LOCAL 3 EMPLOYEE SECURITY FUND

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. Soc. 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

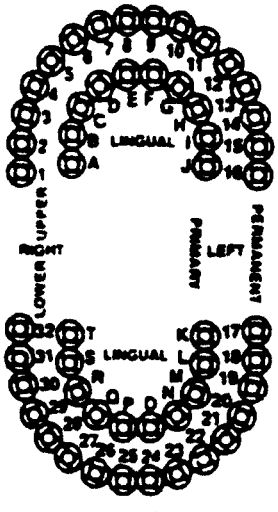
I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

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

SIGNED (PATIENT, OR PARENT IF MINOR) | DATE | 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
		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, limitations and exclusions and remaining maximum at the time of submission for payments,.

® GCIU 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