DENTAL CLAIM FORM

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

NYC PBA FUNDS OFFICE
125 Broad Street, 11th Floor New York, N.Y. 10004
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 * ☐SELF ☐SPOUSE ☐DGHTR ☐SON ☐STEP-CHILD ☐OTHER*
7. PATIENT'S DATE OF BIRTH / /
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.

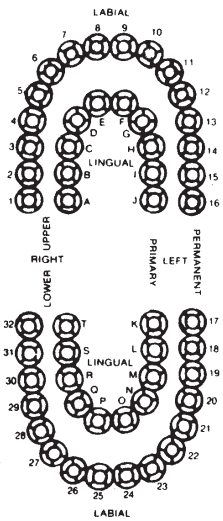
I HEREBY CERTIFY THAT ALL SERVICES LISTED BELOW WITH A DATE OF SERVICE HAS BEEN DONE AND/OR REQUEST PRE-CERTIFICATE FOR TREATMENT PLAN LISTED WITHOUT DATES OF SERVICE.

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	
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PLEASE PRINT ONE PROCEDURE PER LINE

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

TOTAL FEE CHARGE

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

SIGNED (DENTIST) _____ DATE _____

TOTAL BENEFIT
C.O.B.

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

PBA-14 (Rev. 2/03)

(SEE OTHER SIDE ➜)

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