

MAIL THIS CLAIM FORM PROMPTLY TO:
 ProBenefits Administrators
 100 Corporate Parkway, Suite 342
 Amherst, NY 14226

New York City Transit

Attending Dentist's Statement

Patient Section															
Check on: <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services															
1. Patient name first m.i. last			2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other			3. Sex M F		4. Patient birthdate MM DD YYYY		5. If full time student school city					
6. Employee's name and mailing address			7. Employee Social Security Number			8. Employee birthdate MM DD YYYY		9. Employer (company) name and address NYCT Plan B		10. Group number 60070					
11. Is patient covered by another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate:			12-a. Name and address of carrier(s).			12-b. Group no.(s)		13. Name and address of employer							
AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Provider, Insurer, or other Organization to release any information regarding any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.						Signed (Patient or parent if minor)			Date						
AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named dentist of the dental benefits otherwise payable to me.						Signed (Employee)			Date						
CERTIFICATION - I certify that the foregoing information is true and correct.						Signed (Patient or parent if minor)			Date						
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.															
Dentist Section															
14. Dentist name					22. Is treatment result of occupational illness or injury?		No	Yes	If yes, enter brief description and dates.						
15. Mailing address					23. Is treatment a result of auto accident?										
City, State, Zip					24. Other accident?										
16. Dentist Soc. Sec. or T.I.N.					17. Dentist license no.		18. Dentist phone no.		26. If prosthesis, is this initial placement?		(If no, reason for replacement)		27. Date of prior placement		
19. First visit date current series		20. Place of treatment Office Hosp		21. Radiographs or models enclosed? No Yes How many?		23. Is treatment for orthodontics?		If services already commenced enter:		Date appliances placed		Mos. treatment remaining			
Identify missing teeth with an 'x' FACIAL			29. Examination and treatment plan: List in order from tooth no. 1 through tooth no. 32. Use the charting system shown.			Date service performed mo. day year		Procedure number		Fee		For administrative use only			
			Tooth # or letter			Description of service (including x-rays, prophylaxis, material used, etc.)									
UPPER			1												
RIGHT LINGUAL LEFT			2												
LOWER			3												
FACIAL			4												
30. Remarks for unusual services			5												
			6												
			7												
			8												
			9												
			10												
			11												
			12												
			13												
			14												
			15												
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.												Total Fee Charged			
Signed (Dentist) _____ Date _____												Max allowable			
												Deductible			
												Carrier %			
												Carrier pays			
												Patient pays			