RETURN TO:
UNITED PROBATION OFFICERS

375 West Broadway
4th Floor
New York, NY 10012
(212) 226-1069

United Probation Officers Association
Welfare Fund and Retirement Welfare Fund Dental Claim

☐ **PRE-TREATMENT ESTIMATE**
(REQUIRED FOR INLAYS, CROWNS, LAMINATE VENEERS, BRIDGES, DENTURES, PERIODONTAL SURGERY, OR WHEN EXPENSES WILL EXCEED $500 IN A 90 DAY PERIOD)

☐ **PAYMENT CLAIM**
PLEASE SUBMIT PRE & POST TREATMENT X-RAYS FOR ROOT CANAL THERAPY AND NON-ROUTINE EXTRACTIONS

PATIENT INFORMATION *(REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)*

Patient Name (if a dependent)	Birth date	Relationship to Member Spouse ☐ Child ☐	Full Time College Student Yes ☐ No ☐	School

MEMBER INFORMATION

Member Name	Birth date	Sex	Social Security#

Street Address	City	State	Zip	Telephone#
				( )

Work Phone #	Home Phone #	Check Type of Medical Coverage You Have Selected
		G.H.I.-C.B.P. ☐ Other ☐

SPOUSE INFORMATION *(REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)*

Spouse's Name	Spouse's Birth date	Spouse's Social Sec. #	Is spouse covered by another Dental Benefits Plan? If Yes, Specify Below. ☐ Yes ☐ No

Name of Other Company/Organization Providing Benefits	Policy/Plan Number

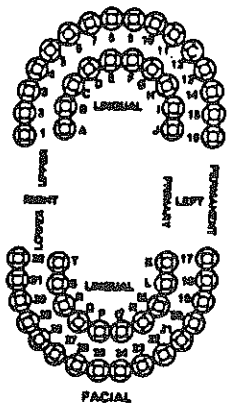
DENTIST INFORMATION *(TO AVOID PROCESSING DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, ETC.)*

Dentist's Name (Print)	License #	Telephone #	Taxpayer ID#

Street Address	City	State	Zip Code

If Prosthesis, is this initial placement? Yes ☐ No ☐	Date of Prior Placement	Reason for Replacement	IS THIS CLAIM THE RESULT OF: Accident Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

DENOTE MISSING TEETH WITH AN "X"



PLEASE CHART PROPOSED OR RENDERED TREATMENT

Tooth # or Letter	Surface	Description of Service (including radiographs, prophylaxis, materials used, etc.	Date Service Performed	Procedure Number	Fee

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A 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.

TOTAL FEE CHARGED

I hereby certify the accuracy of the procedures and dates of completion as listed above.

Signed (Dentist) _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION: **(If Patient is a legal adult, patient's signature is required under Authorization for Release of Information)**
I hereby authorize any insurance company, prepayment organization, employer, hospital, or dentist, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the information submitted by me in support of this claim is true and correct. **Authorization must be signed or payment will not be made.**

Signed (Member) SIGNATURE ON FILE IS NOT ACCEPTABLE _____ Date _____

ASSIGNMENT OF BENEFITS: *I hereby authorize payment directly to the above named dentist of the benefits otherwise payable to me. I understand I am financially responsible to the dentist for charges not covered by this authorization.*

Signed (Member) SIGNATURE ON FILE IS NOT ACCEPTABLE _____ Date _____

GROUP

FOR OFFICE USE ONLY: We certify that the patient is covered by our group contract as indicated by subscribers above, and is eligible for benefits.	Date Eligible	Type of Contract ☐ Active ☐ Retired	By	Date