

DISTRICT COUNCIL 37 HEALTH AND SECURITY PLAN
125 BARCLAY STREET, NEW YORK, N.Y. 10007-2179
(212) 815-1234



M E M B E R R	<input type="checkbox"/> PRE-AUTHORIZATION - OR - <input type="checkbox"/> CLAIM FOR COMPLETED SERVICES									
	MEMBER'S NAME (LAST) (FIRST) (M.I.)				SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH MONTH DAY YEAR			
	MEMBER'S PERSONAL ID NO. OR SOCIAL SECURITY NO. --- ---				HOME TELEPHONE NUMBER (INCLUDE AREA CODE) () ---					
	HOME NO. STREET CITY(BOROUGH) STATE APT NO. ZIP CODE									
	MEMBER'S EMPLOYER (NAME AND ADDRESS)						OFFICE TELEPHONE NUMBER (INCLUDE AREA CODE) () ---			
	SPOUSE'S/DOMESTIC PARTNER'S NAME (LAST) (FIRST) (M.I.)				SPOUSE'S/DOMESTIC'S PARTNER'S SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE					
	SPOUSE'S/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER --- ---				SPOUSE'S/DOMESTIC PARTNER'S DATE OF BIRTH MONTH DAY YEAR					
	OTHER DENTAL COVERAGE, CARRIER NAME <input type="checkbox"/> NO <input type="checkbox"/> YES				IF YES, NAME AND ADDRESS OF SPOUSE/DOM. PARTNER'S EMPLOYER					
	PATIENT'S NAME (LAST) (FIRST) (M.I.)									
	D E N T I S T	PATIENT'S RELATIONSHIP TO MEMBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE/DOMESTIC PARTNER <input type="checkbox"/> CHILD				IS CHILD EMPLOYED FULL-TIME <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF BIRTH MONTH DAY YEAR		
DENTIST'S NAME (LAST) (FIRST)				DENTIST SOCIAL SECURITY NO. OR TAX ID NO.						
MAILING ADDRESS: NO. STREET CITY ZIP CODE				OFFICE TEL. NUMBER () --		PARTICIPATING PANEL DENTIST <input type="checkbox"/> YES <input type="checkbox"/> NO				
TREATMENT RESULTING FROM <input type="checkbox"/> WORK ACCIDENT <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER ACCIDENT DATE: MONTH DAY YEAR										
REPLACEMENT OF PROSTHESIS: DATE: MONTH DAY YEAR <input type="checkbox"/> YES <input type="checkbox"/> NO				ORTHODONTIA TREATMENT APPLIANCE INSERTION DATE: MONTH DAY YEAR						
<u>PERMANENT</u>				PLACE AN "X"		<u>DECIDUOUS:</u>				
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17				ON EACH		A B C D E F G H I J T S R Q P O N M L K				
<u>MISSING TOOTH</u>										
TOOTH SYSTEM		ORAL CAVITY	TOOTH	SURFACE	CDT PROCEDURE CODE NUM.		PROCEDURE DESCRIPTION	PROCEDURE DATE	FEE	
REMARKS:								TOTAL FEE:		
ALL CLAIM FORMS SHOULD BE FULLY COMPLETED, SIGNED AND RETURNED TO THE PLAN OFFICE AT THE ABOVE LISTED ADDRESS. MEMBER MUST SIGN AND CHECK ONE BOX ONLY INDICATING PAYMENT TO MEMBER OR DENTIST FOR CLAIMS FOR COMPLETED SERVICE.										
To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim				Member's signature is required on all claim forms, photocopy of member's signature is not acceptable. I hereby verify that the Pre-Authorization or Claim for Completed Services, listed procedures with service dates, are accurate and that all services indicated by date have been completed.				I certify that my submittal of the Pre-Authorization Plan or Claim for Completed Services, listing procedures indicated by date, are accurate and that all services indicated by date have been completed and furthermore I certify that all crowns, bridges and dentures have been inserted.		
Patient/Guardian Signature _____ Date _____				Member's Signature _____ Date _____				Dentist's Signature _____ Date _____		
FOR DC37 USE ONLY				FOR CLAIM FOR COMPLETED SERVICES				UNDER SECTION 6109 OF THE INTERNAL REVENUE CODE RECIPIENTS OF MEDICAL AND HEALTH CARE PAYMENT ARE REQUIRED TO FURNISH IDENTIFYING NO. TO PAYERS WHO MUST REPORT SUCH PAYMENTS TO THE INTERNAL REVENUE SERVICE.		
Cl. Examiner: _____ Date: _____				Please make payment to <input type="checkbox"/> Member Please make payment to <input type="checkbox"/> Dentist						

A FAILURE TO COMPLY WITH THE INSTRUCTIONS WILL RESULT IN A DELAY OF THE PROCESSING OF YOUR CLAIM OR A REJECTION OF PAYMENT

Important Notes

Pre-authorization is mandatory before beginning treatment for prosthetics (dentures and bridgework), single crowns, extensive gum treatment, TMJ therapy, root canal therapy or orthodontics. **YOU MUST SUBMIT A PRE-AUTHORIZATION PLAN FOR THE ABOVE LISTED SERVICES OR YOUR CLAIM WILL BE REJECTED.** The Plan office reviews the pre-authorization plan, then notifies you and your dentist if the intended work is covered and for how much. **THIS ASSUMES, OF COURSE, THAT YOU ARE ELIGIBLE FOR BENEFITS WHEN THE WORK IS PERFORMED,** and takes into consideration the Plan's rules and regulations regarding yearly maximums and frequency limitations for certain procedures. Payment will be made only if you are eligible at the time the service is performed. Crown and bridgework should not be started until you and your dentist receive notification about the pre-authorization plan.

The maximum benefit, \$1,700 per calendar year, is based on the Plan's fee schedule. In all circumstances, Plan rules regarding restrictions, limitations, and annual dollar limit will apply.

Instructions for filing a request for pre-authorization or claim for completed services:

Member:

- Complete all information in the member section including spouse/domestic partner dental coverage. If spouse/domestic partner has no other coverage, check NO.
- Patient or guardian of minor child should sign the patient signature box.
- Member must sign and date the form. A photocopy of the member's signature will not be accepted.
- Claims for completed services, member must check one box only indicating payment to member or payment to dentist.

Dentist:

- Complete all information in the dentist section including your social security number or tax I.D. number and complete address.
- In the treatment area, list all procedures and fees separately. Include all information such as tooth number and quadrant codes. **Only CDT codes will be accepted.**
- All necessary mounted x-rays should be submitted along with a request for pre-authorization or claims for completed services.

Submit all requests for pre-authorization or claims for completed services to the DC 37 Health and Security Plan, 125 Barclay Street, New York, N.Y. 10007. All correspondence to the Plan office should include the member's name, social security number or PID # (personal identification number).

You must file a claim for completed services within 30 days after the completion of work. Claims for orthodontic services may be submitted monthly, but no later than quarterly.

NO CUMPLIR CON LAS INSTRUCCIONES CAUSARÁ QUE SE RETRASE EL TRÁMITE DE SU RECLAMO O QUE EL PAGO SEA RECHAZADO.

Notas importantes

Es obligatorio tener una autorización previa antes de empezar el tratamiento de prótesis (dentaduras y trabajo de puente), coronas solas, tratamiento extensivo de encías, terapia TMJ, terapia de raíces u ortodoncia. **DEBE PRESENTAR UN PLAN DE PREAUTORIZACIÓN PARA LOS SERVICIOS ARRIBA MENCIONADOS. SI NO, SE LE RECHAZARÁ SU RECLAMO.** La oficina del Plan revisa el plan de preautorización y después le notifica a usted y a su dentista si el trabajo que se busca hacer está cubierto y cuánto dinero cubre. **ASUMIENDO, POR SUPUESTO, QUE USTED TIENE DERECHO A RECIBIR PRESTACIONES CUANDO SE REALIZA EL TRABAJO,** y tomando en cuenta las reglas y regulaciones del Plan sobre cantidades máximas permitidas cada año y frecuencia permitida para ciertos procedimientos. Antes de empezar el tratamiento para dentaduras y trabajo de puentes el dentista y el miembro deben recibir un plan de preautorización.

El máximo de prestaciones permitidas es de \$1,700.00 por cada año, del calendario natural, con base en el programa de cuotas del Plan. En cualquier circunstancia se aplicarán las reglas del Plan respecto a restricciones, límites, y límites de dólares anuales.

Instrucciones para llenar una solicitud de preautorización o de reclamo para servicios ya hechos.

El trabajador miembro:

- Complete toda la información en la parte sobre el trabajador miembro, incluyendo la cobertura dental de su esposo(a)/pareja de convivencia. Si el(la) cónyuge no tiene ninguna otra cobertura, ponga "NO".
- Un paciente o encargado de un niño menor debe firmar en el cuadro de la firma del paciente.
- El trabajador miembro debe firmar el formulario y ponerle fecha. No se aceptará una copia fotostática de la firma del trabajador.
- Para reclamar servicios ya hechos, el trabajador miembro debe marcar sólo un cuadro indicando el pago al trabajador o el pago al dentista.

El dentista:

- Complete toda la información en la parte sobre el dentista, incluyendo su número de seguro social, o de identificación de contribuyente de impuestos, y su dirección completa.
- En la parte sobre el tratamiento, haga una lista de todos los procedimientos y cuotas por separado. Incluya toda la información, como número de diente y códigos de cuadrante. Sólo se cód. de cuadrante.
- Todas las radiografías necesarias acumuladas deberán presentarse junto con una solicitud de preautorización o de reclamos por servicios ya hechos.

Presente todas las solicitudes de preautorización o reclamación por servicios terminados a: DC 37 Health and Security Plan 125 Barclay Street, New York, N.Y. 10007. Todas correspondencia del plan debe de incluir el nombre y el numero de seguro social o PID # (numero de identificacion personal).

Debe presentar un reclamo por servicios ya hechos en un plazo de 30 días después de terminar el trabajo. Los reclamos por servicios de ortodoncia deben presentarse mensualmente, a más tardar trimestralmente.