PLEASE PRINT AND RETURN COMPLETED FORM TO:

Claim for Group Dental Benefits

BUFFALO TEACHERS FEDERATION
SUPPLEMENTAL BENEFIT FUND
271 PORTER AVENUE
BUFFALO, NEW YORK 14201

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

PATIENT SECTION

1. MEMBER'S NAME — FIRST / MIDDLE / LAST
2. SOCIAL SECURITY NO
3. NAME OF GROUP DENTAL PROGRAM: **SUPPLEMENTAL BENEFIT FUND**
4. MEMBER'S MAILING ADDRESS
5. MEMBER'S PAYROLL SCHOOL
PREVIOUSLY USED BTF/SBF DENTAL PLAN? Yes ☐ No ☐
CITY, STATE, ZIP
MEMBER'S HOME PHONE
MEMBER'S SCHOOL PHONE
6. PATIENT'S NAME
7. RELATIONSHIP TO MEMBER — SELF / SPOUSE / CHILD / OTHER
8. SEX — M / F
9. PATIENT'S BIRTHDAY — MO / DAY / YEAR
10. IS MEMBER MARRIED? ☐ Yes ☐ No
IS SPOUSE EMPLOYED? ☐ Yes ☐ No
11. SPOUSE'S NAME
12. NAME AND ADDRESS OF EMPLOYER
13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN
DENTAL PLAN NAME
UNION LOCAL
GROUP NO
NAME AND ADDRESS OF CARRIER

UNDER PENALTY OF LOSS OF ALL SUPPLEMENTAL BENEFITS, THE INFORMATION ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

▶ SIGNED (PATIENT OR PARENT, IF MINOR) DATE

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

▶ SIGNED (INSURED PERSON) DATE

DENTIST SECTION

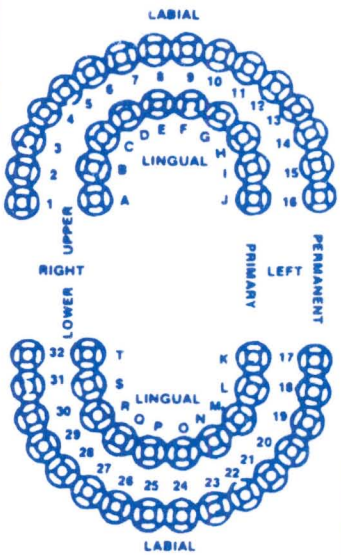
14. DENTIST'S NAME
15. MAILING ADDRESS
CITY, STATE, ZIP
16. DENTIST SOC. SEC. OR T.I.N.
17. DENTIST LICENSE NO
18. DENTIST PHONE NO
19. IMPRESSION DATE IS USED FOR REIMBURSEMENT PURPOSES FOR ALL PROSTHODONTIC SERVICES
IMPRESSION DATE:
CEMENTATION DATE:

THE CLAIMANT MUST BE ELIGIBLE FOR BENEFITS WHEN THE SERVICES ARE ACTUALLY RENDERED

CLAIMS MUST BE RECEIVED FOR PAYMENT WITHIN SIX MONTHS OF THE SERVICE DATE

20. ARE ANY SERVICES COVERED BY ANOTHER PLAN?
21. IF PROTHESIS, IS THIS INITIAL PLACEMENT? (IF NO, REASON FOR REPLACEMENT) 22. DATE OF PRIOR PLACEMENT
23. IS TREATMENT FOR ORTHODONTICS? IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED MOS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



30. EXAMINATION AND TREATMENT RECORD — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

TOOTH NO. OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIAL USED, ETC.)	DATE SERVICE PERFORMED Mo. Day Yr.	ADA PROCEDURE NUMBER	FEE	BTF-SBF USE ONLY

*The estimates are based on the information we have at present. Estimates are subject to coinsurance and plan maximums and may be reduced by payment made before these services are rendered. Actual payments will be made in the order of claims received.

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

▶ SIGNED (DENTIST) DATE

TOTAL FEE ACTUALLY CHARGED