FA SCC
Benefit Fund

IMPORTANT NOTICE
PRE-DETERMINATION REQUIRED
FOR $600 OR MORE

X-RAYS MUST BE ATTACHED IF CLAIM IS $600 OR MORE

SEE **INSTRUCTIONS ON REVERSE SIDE**

Active ☐
Retired (Basic)) ☐
Retired (Enhanced) ☐

DENTAL CLAIM FORM

RETURN THIS FORM TO
Faculty Association Suffolk Community College Benefit Fund
c/o Daniel H. Cook Associates, Inc.
253 West 35th Street - 12th Floor
New York, New York 10001
(212) 505-5050 9 1-800-342-6651

MEMBER

PATIENT NAME: (print last name first)	SEX ☐ M ☐ F	RELATIONSHIP TO MEMBER ☐ Self ☐ Child ☐ Spouse ☐ Other	PATIENT S.S. #	PATIENT DATE OF BIRTH Mo. DY. YR
MEMBER NAME. print last name first)	SEX ☐ M ☐ F	MEMBER S.S. #	MEMBER DATE OF BIRTH Mo. DY. YR.	BARGAINING UNIT ☐ Act. ☐ Ret. ☐ FA ☐ PT ☐ FA ☐ Guild ☐ Other

HOME ADDRESS. Number and Street	APT.	HOME PHONE (include area code)
CITY	STATE ZIP	WORK PHONE (include area code)

IS YOUR SPOUSE EMPLOYED? ☐YES NO — IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER — SPOUSE'S S.S. 9

ARE DENTAL BENEFITS AVAILABLE FROM ANY OTHER CARRIER FOR THIS PATIENT? ☐ YES ☐ NO IF YES. SPOUSE BIRTHDATE _____ MONTH _____ DAY _____ YEAR

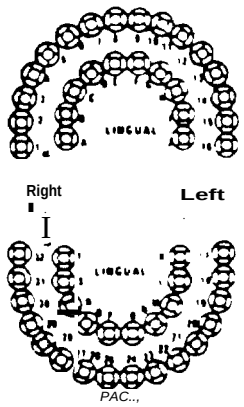
I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. BENEFITS ARE NOT PAYABLE UNDER ANY OTHER GROUP PLAN EXCEPT AS INDICATED ABOVE.

Member Sign Here _____ *Date* _____

DENTIST

DENTIST NAME	**IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?**	**NO**	**Yes**	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS	**IS TREATMENT RESULT OF AUTO ACCIDENT?**			
	OTHER ACCIDENT?			
CITY. STATE, ZIP	**ARE ANY SERVICES COVERED BY ANOTHER PLAN?**			
DENTIST SOC. SEC. or T.I.N. DENTIST LICENSE NO. DENTIST PHONE NO..	**IF PROSTHESIS. IS THIS INITIAL PLACEMENT?**			(IF NO. REASON FOR REPLACEMENT) DATE OF **PRIOR EMPLOYMENT**
FIRST VISIT DATE PLACE OF TREATMENT RADIOGRAPHICS CURRENT SERIES Office Hosp. ECF Other OR MODELS — YES — NO — HOW MANY?	**IS TREATMENT FOR** ORTHODONTICS?			IF SERVICES ALREADY PLACED COMMENCED ENTER: DATE APPLIANCES — MOS. TREATMENT REMAINING

Indicate missing tooth with W



REMARKS FOR UNUSUAL SERVICES ON ATTACMENT CHECK

USE CHARTING SYSTEM AT LEFT. DESCRIBE YOUR TREATMENT PLAN OR SERVICES COMPLETED.

Tooth or Letter	Sur-face	DESCRIPTION *OF* SERVICE (including X-RAYS, PROPHYLAXIS. MATERIALS USED. etc.) LINE NO.	Date Service Performed	CDT Procedure Number	FEE	OFF. USE

TOTAL FEE CHARGED

– CHECK ONE ONLY –

☐ DENTIST'S TREATMENT PLAN (PRE-DETERMI NATION):
I hereby certify that the above procedures are necessary to be performed.

Dentist's Signature **Date**

☐ DENTIST'S STATEMENT *OF* ACTUAL SERVICES:
I hereby certify that the above procedures were rendered on the dates indicated.

Dentist's Signature **Oats**

I am a specialist in:
☐ Orthodontics ☐ Oral Surgery
☐ Endodontics ☐ Periodontics
☐ Other

MEMBER

I certify that to the beat of my knowledge the dental procedures listed above were actually performed and the dates on which they performed are accurate. **Signature** _____ **Date** _____

PLEASE NOTE THAT THIS MUST BE SIGNED BY THE MEMBER/PATIENT IN ORDER FOR THIS CLAIM TO BE PROCESSED.

THIS FORM WILL BE RETURNED IF IT IS INCOMPLETE OR INCORRECT

NOTICE TO MEMBERS

PRE -DETER M I NATION BY THE FUN D'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST CHARGES WILL AMOUNT TO $600 OR MORE. X- RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-DETERMINATION. Pre-determination by the Fund's Dental Consultant is limited to the approval of the course of treatment proposed; it does not include approval of payment for services not covered under the Dental Plan, the patient's eligibility or guaranteed payment. Completed treatment accounting to $1,000 or more may require examination of patient by Fund's Consultant Dentist before payment is made.

9 CLAIM MUST BE SUBMITTED WITHIN ONE YEAR AFTER COMPLETION OF COURSE OF DENTAL TREATMENT.

0 Bring a claim form with you when you visit your dentist. Complete your part - give all the information required. DISCUSS FEES BEFORE SERVICES ARE PERFORMED. If you have any questions about your dental benefits, contact the Dental Program Administrator.

0 A covered patient may go to any dentist, anywhere, and the amount of payment is the same regardless of the dentist chosen.

0 Please make sure you have signed the dental procedure certification box on the bottom of the claim form.

0 Mail this form to: Faculty Association Suffolk Community College
Benefit Fund
c/o Daniel H. Cook Associates, Inc.
253 West 35th Street - 12th Floor
New York, New York 10001 Telephone: (212) 505-5050 or 1-800-342-6651

0 Active member and retiree benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees.

DEPENDENT STUDENT COVERAGE: An unmarried child who is a full time student will be covered up to age 25(12 hours enrolled for undergraduate credits or 6 hours graduate credits). Proof of student status must be submitted to the Fund before a claim can be honored. Such proof consists of completion of FA Benefit Fund Student Verification Form or a letter from the college or university attesting to his/her full time attendance during the period that dental services were performed. If this proof has already been recorded with the Fund, it is not necessary to resubmit it with this claim.

NOTICE TO DENTISTS

0 Please note that copies of signatures and "signatures on file" will not be accepted by the Fund office and the claim form will be returned to you. There is no assignment of benefits under this dental program unless you are a participating provider.-

0 Pre-Treatment Determination must be filed not later than 30 days after examination.

0 If services rendered are for emergency treatment or due to an accidental injury, Pre-Determination will not be necessary.

0 PRE-DETERMINATION BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST CHARGES WILL AMOUNT TO $600 OR MORE. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE- DETER MI NATION. Pre-determination by the Fund's Dental Consultant is limited to the approval of the course of treatment proposed; it does not include approval of payment for services not covered under the Dental Plan, the patient's eligibility or guaranteed payment. Completed treatment amounting to $1,000 or more may require examination of patient by Fund's Consultant Dentist before payment is made.

0 All procedures must have corresponding CDT/ADA procedure codes listed in order to be processed.

FUND DENTAL CONSULTANT REMARKS:

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ANYONE INTENTIONALLY MISUSING THIS FORM FOR THE PURPOSE OF OBTAINING IMPROPER PAYMENTS IS SUBJECT TO APPROPRIATE ACTION.