



SUFFOLK COUNTY SUPERIOR OFFICERS ASSOCIATION
- BENEFIT FUND -
 2518 Montauk Highway, Brookhaven, NY 11719 -Tel. (631) 654-0900

<input type="checkbox"/> Dentist's Pre-Treatment Estimate <input type="checkbox"/> Dentist's Statement of Actual Services SERVICES OVER \$350.00 REQUIRES PRIOR APPROVAL					
Patient Name	Relationship to Employee Self Spouse Child Other	Sex M F	Mo. Patient Birthdate Day Year	If Fulltime Student School	City
Member's Name - Last Middle First	Soc. Sec. No.	Name of Group Dental Program SAME AS ABOVE - SELF-INSURED			
Mailing Address	Are other family members employed? Employee Name		Soc. Sec. No.		
City State Zip	Name and Address of Employer				
Is patient covered by another dental plan? Dental Plan Name	Union Local	Group No.	Name and Address of Carrier		

I have reviewed the following treatment plan. I authorize release of any x-rays and information relating to this claim. Member's Signature		Date		I hereby authorize payment of Welfare Fund benefits made directly to the DENTIST named below. I understand that I am financially responsible for any charges not covered by the plan. Member's Signature		Date	
Dentist Name	Is treatment result of occupational illness or injury?		Yes	No	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 Identification No.	Dentist Phone No.		If Prosthesis, if this initial placement?				
First visit date current series	Place of Treatment Office Hosp. ECF Other	Radiographs or models enclosed?	Yes	No	How Many?	Is treatment for orthodontics?	

Identify Missing Teeth with an "X" FACIAL FACIAL Remarks for unusual services	Examination and Treatment plan. List in order from Tooth No. 1 through Tooth No. 32 - Use Charting system shown.						For Administrative Use Only	
	Tooth # or Letter	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Material used, etc.)	Date Service Performed Mo. Day Year		Procedure Number		Fee

I hereby certify that the procedure as indicated by date have been completed.		Total Fee	Total Allowance
Signed (Dentist)	Date		
This space reserved for Dental Consultant James L. Mercadante, D.D.S.		Verified by	Returned
		Date	Processed by
		X-Rays	Date
		Study Models	

