MAIL COMPLETED CLAIM FORM TO:
140 Broadway
Hawthorne, NY 10532
Tel: (914) 769-2440

WESTCHESTER PUTNAM COUNTIES HEAVY & HIGHWAY LABORERS LOCAL 60 BENEFITS FUND

Part I – To Be Completed By Member.

1. PATIENT NAME	2. RELATIONSHIP TO MEMBER: Self / Spouse / Child / Other	3. SEX: M / F	4. PATIENT BIRTHDATE: Mo. / Day / Year	5. IF FULL TIME STUDENT: School

6. MEMBERS NAME: First / Middle / Last	7. MEMBERS SOCIAL SECURITY NO.	

8. MEMBERS MAILING ADDRESS	9. EMPLOYER (COMPANY) NAME AND ADDRESS
CITY, STATE, ZIP	

10. ARE OTHER FAMILY MEMBERS EMPLOYED? Employee Name / Soc. Sec. No.	11. NAME AND ADDRESS OF EMPLOYER IN ITEM 13

12. 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 INFORMATION RELATING TO THE CLAIM.

X ______________________ ____________
SIGNED (PATIENT OR PARENT IF MINOR) DATE

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

X ______________________ ____________
SIGNED (EMPLOYEE) DATE

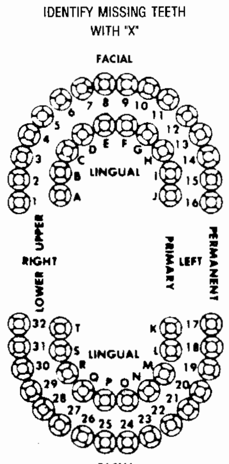
Part II – To Be Completed By Attending Dentist – Refer to Nomenclature and codes before completing this part.

(1) DENTIST NAME		(8) IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
(2) MAILING ADDRESS		(9) IS TREATMENT RESULT OF AUTO ACCIDENT?			
		OTHER ACCIDENT?			
CITY, STATE, ZIP		(10) ARE ANY SERVICES COVERED BY ANOTHER PLAN?			

(3) DENTIST SOC. SEC. OR T.I.N.	(4) DENTIST LICENSE NO.	(5) DENTIST PHONE NO.	(11) IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR PLACEMENT	(12) DATE OF PRIOR PLACEMENT

(6) FIRST VISIT DATE–CURRENT SERIES	(7) RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY?	(13.) IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER	DATE APPLIANCES PLACED	MOS. TREATMENT REMAINING

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



(14) EXAMINATION AND TREATMENT PLAN LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32 USE CHARTING SYSTEM SHOWN.

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MO.	DAY	YR.	PROCEDURE NUMBER	FEE

DENTIST CERTIFICATION FOR SERVICES PROVIDED
I certify that the above services were provided and completed by me.

Dentist Signature ______________________ Date ____________

TOTAL FEE CHARGED

DENTAL INFORMATION Payment will be made provided treatment is performed while the patient is covered. Payment will be made subject to all limitations and maximums.

NOT TO BE SIGNED BY MEMBER UNTIL WORK IS COMPLETED. I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED TO MY SATISFACTION.

Member Signature ______________________ Date ____________

USWA LABEL