Plan Name and Mailing Address:

ROOFERS LOCAL #22
FUND OFFICE
280 METRO PARK
ROCHESTER, NY 14623
(585)235-0829 (work)

CLAIM AUTHORIZATION FORM

Employee Statement

1. Patient name | 2. Relationship to employee ☐ self ☐ wife ☐ husband ☐ daughter ☐ son ☐ stepchild ☐ foster child | 3. ☐ M ☐ F | 4. Patient birthdate month day year | 5. If full-time student School City

6. Employee name First Middle Last

Plan Roofers Local 22

9. Employee/mailing address Is this a new address? ☐ yes ☐ no
City State ZIP

10. Employer (company) name and address
City State ZIP

11. Is employee ☐ single ☐ married ☐ divorced ☐ widowed

15. Is patient covered by another plan of benefits? Dental ☐ yes ☐ no
If "yes," give name of person carrying the other coverage.
Dental plan name
Name and address of carrier

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.
Signed (patient or parent if minor) Date

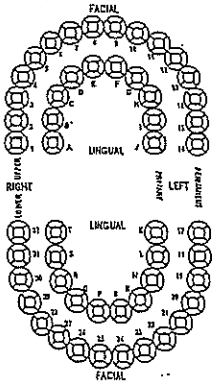
I hereby authorize payment directly to the below-named dentist of the dental benefits otherwise payable to me
Signed (employee) Date

Attending Dentist's Statement

16. Dentist name
17. Mailing address
City State ZIP
18. Dentist T.I.N.
19. Dentist license number/ anesthesia license number
20. Dentist phone number
21. First visit date current series
22. Place of treatment Office | Hosp. | ECF | Other
23. Radiographs or models enclosed? no | yes | How many?

		no	yes	If yes, enter brief description and dates
24.	Is treatment result of occupational illness or injury?			
25.	Is treatment result of auto accident?			
26.	Other accident?			
27.	Are any services covered by another plan?			
28.	If prosthesis, is this first placement of any type?			(If no, reason for replacement) 29. Date of prior placement
30.	Is treatment for orthodontics?			If services already commenced, enter Date appliances placed Mos. treatment remaining

Identify missing teeth with "X"



31. Examination and treatment plan - List in order from tooth number 1 through tooth number 32 - Use charting system shown.

Tooth number or letter	Surface	Description of service (including X-rays, prophylaxis, materials used, etc.) line number	Date service performed mo. day year	Procedure number	Fee

FOR ADMINISTRATIVE USE ONLY

TOTAL FEE CHARGED

32. Remarks for unusual services

Covered Charges
Less Deductible
___ @ ___ %
___ @ ___ %
___ @ ___ %
Total Estimated Benefits

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Dentist) Date