DISTRICT COUNCIL 37 HEALTH AND SECURITY PLAN
125 BARCLAY STREET, NEW YORK, N.Y. 10007-2179
(212) 815-1234

Health & DC 37 Security Plan

MEMBER INFORMATION:

Member SSN/PID:	Gender: ☐M ☐F
Last/First Name:	
Street Address:	
C/O Address:	
City/State/Zip:	
Phone #:	Birthday:
Employer Name:	
Street Address:	
City/State/Zip:	

SPOUSE / DOMESTIC PARTNER INFORMATION:

Spouse SSN:	Gender: ☐M ☐F
Last/First Name:	Birthday:
Employer Name:	
Insurance Co.:	
Street Address:	
City/State/Zip:	

☐ **PRE -AUTHORIZATION --OR--**

☐ **CLAIM FOR COMPLETED SERVICES**

PATIENT INFORMATION:

Patient First Name:	
Patient Birthday:	Gender: ☐M ☐F
Relationship:	☐ Self ☐ Spouse/Domestic Partner ☐ Child

PROVIDER INFORMATION:

Last/First Name:	
Facility Name:	
Street Address:	
City/State/Zip:	
Tax ID#:	
NPI #:	
Phone #:	
Participating Panel Dentist:	☐ YES ☐ NO
Orthodontia Treatment Appliance Insertion Date:	Month Day Year
Replacement of Prothesis:	☐ YES ☐ NO Month Day Year

TREATMENT INFORMATION:

PERMANENT:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

PLACE AN "X" ON EACH MISSING TOOTH

DECIDUOUS:

A B C D E F G H I J

T S R Q P O N M L K

Tooth System	Oral Cavity	Tooth Number	Surfaces	Date of Service	Procedure CDT Code	Procedure Description:	Fee Charge

Remarks: **Total Treatment Charges:**

ALL CLAIM FORMS SHOULD BE FULLY COMPLETED, SIGNED, AND RETURNED TO THE PLAN OFFICE AT THE ABOVE LISTED ADDRESS.
MEMBER MUST SIGN AND CHECK ONE BOX ONLY, INDICATING PAYMENT TO MEMBER OR DENTIST FOR CLAIMS FOR COMPLETED SERVICE.

To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim

Patient/Guardian Signature _____ Date _____

Member's Signature is required on all claim forms, photocopy of signature is not acceptable. I hereby verify that the Pre-Authorization or Claim for Completed Services, listed procedures with service dates are accurate and that all services indicated by date have been completed.

Member's Signature _____ Date _____

I certify that my submittal of the Pre-Authorization Plan or Claim for Completed Services, listing procedures indicated by date, are accurate and that all services indicated by date have been completed and furthermore I certify that all crowns, bridges, and dentures have been inserted.

Dentist's Signature _____ Date _____

FOR DC37 USE ONLY

Claim Examiner: _____

Date: _____

FOR CLAIM FOR COMPLETED SERVICES

Please make payment to ☐ Member

Please make payment to ☐ Dentist

UNDER SECTION 6109 OF THE INTERNAL REVENUE CODE, RECIPIENTS OF MEDICAL AND HEALTH CARE PAYMENT ARE REQUIRED TO FURNISH IDENTIFYING NO. TO PAYERS WHO MUST REPORT SUCH PAYMENTS TO THE INTERNAL REVENUE SERVICE.