IMPORTANT NOTICE
Pre-Authorization is required for claims of $500 or more. All claims must be filed within six (6) months of date of service.

X-RAYS MUST BE ATTACHED

RETURN THIS FORM TO:
Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
Tel. 1-800-573-7474 - Fax 518-641-0325

BTA WELFARE FUND

MEMBER — PLEASE PRINT

Patient Name	Relationship to Member (Self / Spouse / Child / Other)	Sex (M / F)	Patient's Birthdate (Mo. / Day / Year)	Patient's Social Security Number — —
Member's Last Name	First Name	Initial		Member's Social Security Number — —
Full Mailing Address	No. and Street		Apt. No.	Home Telephone No.
City	State	Zip Code	IS THE ABOVE ADDRESS DIFFERENT FROM YOUR LAST CLAIM FILED? Yes ☐ No ☐	IS THIS THE FIRST DENTAL CLAIM FILED BY YOU? Yes ☐ No ☐
Member's Building	Member's Office Telephone No.		Member's Birthdate (Mo / Day / Year)	
Is Your Spouse Employed Yes ☐ No ☐	If "YES", give name and address of your Spouse's employer.			
Are Dental Benefits Available From Any Other Group Insurance Carrier For This Patient? Yes ☐ No ☐	If "YES", give name of carrier, plus name and I.D. No. of subscriber.			Spouse's Birthdate ____ Month ____ Day

I certify that the information given is correct and authorize release of any information necessary to process this claim. Benefits are not available under any other Group Plan except as indicated above.

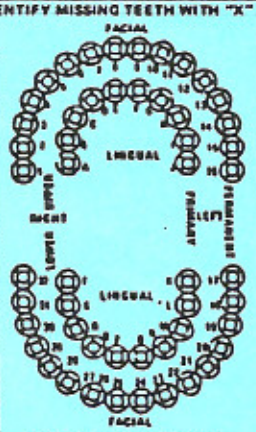
Benefits are payable to member only.

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 PLACEMENT
FIRST VISIT DATE CURRENT SERIES / PLACE OF TREATMENT: OFFICE, HOSP., ECF, OTHER / RADIOGRAPHICS OR MODELS ENCLOSED? YES NO HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES ON ATTACHMENT CHECK ☐

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

TOOTH OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED	ADA PROCEDURE NUMBER	FEE	OFFICE USE ONLY

— CHECK ONE ONLY —

☐ DENTIST'S TREATMENT PLAN (PRE-DETERMINATION OF BENEFITS):
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 DATE

TOTAL FEE CHARGED

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

OFFICE

CLAIM NO.

DENTAL CONSULTANT
PRE-AUTH. APPROVAL: _____ DATE _____

REV. 1-01