Toledo Firefighters Health Plan

41

714 Washington Street
Toledo, Ohio 43624

PART 1 MUST BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	NAME OF EMPLOYER	
HOME ADDRESS	EMPLOYEE BIRTH DATE MONTH DAY YEAR	OCCUPATION	Fund Number
CITY & STATE / ZIP CODE	PHONE NO.	IS PATIENT FULL TIME STUDENT YES ☐ NO ☐	NAME & ADDRESS OF SCHOOL
PATIENT (IF OTHER THAN EMPLOYEE) NAME	SEX / PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT BIRTH DATE MONTH DAY YEAR	IS PATIENT MARRIED YES ☐ NO ☐
DATE ACCIDENT OR SICKNESS BEGAN	IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?		DID ACCIDENT HAPPEN AT WORK? YES ☐ NO ☐
NATURE OF INJURY DIAGNOSIS		PHYSICIAN'S NAME	
NAME OF SPOUSE	NAME AND ADDRESS OF SPOUSE'S EMPLOYER		

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THE EXPENSES OF THIS CLAIM? YES ☐ NO ☐ IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF PLAN PROVIDING BENEFITS.

NAME AND ADDRESS POLICY NO.

IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW

AUTHORIZATION TO PAY BENEFITS TO PROVIDERS
I hereby authorize payment of benefits directly to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Covered Person Date

PATIENT OR PARENT MUST SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

X _____
Patient or Parent (if minor) Date

PART 2 TO BE COMPLETED BY DENTIST

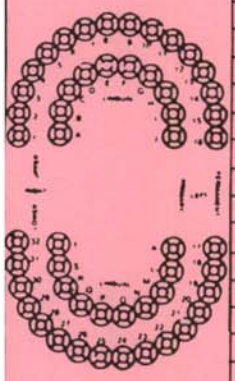
PATIENT'S NAME	BIRTH DATE	DOES PATIENT HAVE OTHER COVERAGE? YES ☐ NO ☐	IF YES, PLEASE IDENTIFY

FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFFICE HOSPITAL ECF OTHER	RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐	HOW MANY	IS TREATMENT FOR ORTHODONTICS? YES ☐ NO ☐	IF SERVICES ALREADY COMMENCED ENTER	DATE APPLIANCES PLACED / MOS. TREATMENT Remaining

IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.	DATE OF PRIOR PLACEMENT?	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? YES ☐ NO ☐	IF YES, ENTER BRIEF DESCRIPTION AND DATES

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

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

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

		DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE	ADMINISTRATIVE USE

COORDINATION OF BENEFITS	PHYSICIAN'S NAME	SOC. SEC. #	TOTAL FEE CHARGED
Amount Charged _____	ADDRESS	I.D. #	MAX. ALLOWABLE
Amount C.O.B. _____	CITY (ZIP)		DEDUCTIBLE
Balance Due _____	DEGREE	PHONE	% OF PAYMENT
	I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE PERFORMED ☐ HAVE BEEN PERFORMED ☐		PLAN PAYS
	DENTIST'S SIGNATURE _____		PATIENT PAYS