

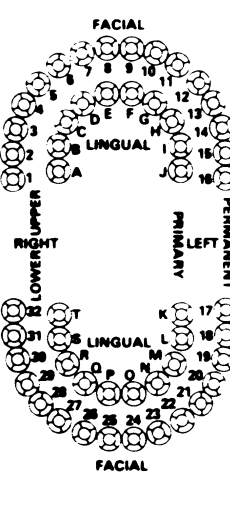
ATTENDING DENTIST'S STATEMENT

Check one: <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services	Carrier name and address
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PATIENT COVERAGE INFORMATION	1. Patient name first _____ m.i. _____ last _____	2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____	3. Sex m f	4. Patient birthdate MM DD YYYY	5. If full time student school _____ city _____	
	6. Employee/subscriber name and mailing address 	7. Employee/subscriber soc. sec. or I.D. number 	8. Employee/subscriber birthdate MM DD YYYY	9. Employer (company) name and address 		10. Group number
	11. Is patient covered by another dental plan? yes no If yes, complete 12-a. Is patient covered by a medical plan? yes no	12-a. Name and address of carrier(s) 	12-b. Group no.(s) 		13. Name and address of other employer(s) 	
	14-a. Employee/subscriber name (if different than patient's) 	14-b. Employee/subscriber soc. sec. or I.D. number 	14-c. Employee/subscriber birthdate MM DD YYYY	15. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other _____		

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. Signed (Patient, or parent if minor) _____ Date _____	I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. Signed (Insured person) _____ Date _____
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BILLING DENTIST	16. Name of Billing Dentist or Dental Entity 				24. Is treatment result of occupational illness or injury? No Yes		If yes, enter brief description and dates 		
	17. Address where payment should be remitted City, State, Zip _____				25. Is treatment result of auto accident? No Yes				
	18. Dentist Soc. Sec. or T.I.N. 				26. Other accident? No Yes				
	19. Dentist license no. 		20. Dentist phone no. 		27. If prosthesis, is this initial placement? No Yes			(If no, reason for replacement) 	28. Date of prior placement
	21. First visit date current series 	22. Place of treatment Office Hosp. ECF Other	23. Radiographs or models enclosed No Yes How many?	29. Is treatment for orthodontics? No Yes		If services already commenced enter: Date appliances placed: _____ Mos. treatment remaining _____			

Identify missing teeth with "x" 	30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.						For administrative use only
	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year		Procedure number	
31. Remarks for unusual services 							

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 (Treating Dentist) _____ License Number _____ NPI _____ Date _____	Total Fee Charged
Max. Allowable _____ Deductible _____ Carrier % _____ Carrier pays _____ Patient pays _____	

See back of ID card for claim mailing address and customer service phone number.