ATTENDING DENTIST'S STATEMENT

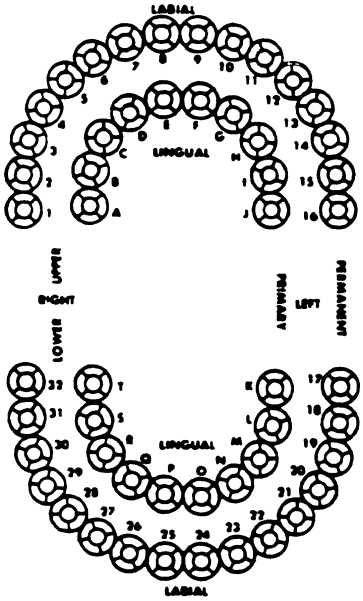
UNIFORM REPORT FORM

CLAIM FILE NUMBER

IMPORTANT! LIST CORRECT PLAN NUMBER ON WHICH CLAIM IS BEING FILED

PART 2. — **TO BE COMPLETED BY THE DENTIST**

1. EMPLOYEE'S NAME:		2. EMPLOYEE'S FULL ADDRESS:			
3. PATIENT'S NAME	4. RELATIONSHIP	5. PATIENT BIRTH DATE (MONTH / DAY / YEAR)	6. DATE PATIENT FIRST VISIT (CURRENT SERIES)		
7. DENTIST NAME 8. LICENSE NO.		9. IS PATIENT COVERED BY ANOTHER PLAN? (NAME OTHER PLAN)		YES	NO
10. DENTIST MAILING ADDRESS 11. PHONE NO.	12. SS# OR TAX ID#	14. IS ANY OF TREATMENT FOR ORTHODONTIC PURPOSES?			
13. CITY STATE ZIP		15. TREATMENT RESULT OF ACCIDENT? 16. RESULT OF OCCUPATIONAL INJURY?			
17. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO	18. IF NO, REASON FOR REPLACEMENT	19. DATE OF PRIOR PLACEMENT	20. X-RAYS ENCLOSED ☐ YES ☐ NO		



INDICATE MISSING TEETH WITH AN "X"

21. EXAMINATION AND TREATMENT RECORD — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32.

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PHROPHYLAXIS MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE	DO NOT USE THIS COLUMN

ORTHODONTICS (give diagnosis, class of malocclusion and describe appliance(s) in above treatment section.)

DATE FIRST APPLIANCE INSERTED _____

DATE LAST APPLIANCE REMOVED _____

TREATMENT PERIOD (Number months) _____

TOTAL FEE $ _____

TOTAL FEE ACTUALLY CHARGED

22. REMARKS FOR UNUSUAL SERVICES

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED.

DENTIST SIGNATURE _____ DATE _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOW ABOVE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

PATIENT'S SIGNATURE _____ DATE _____

(Or parent if patient is a minor)

Approved by the Council on Dental Care Programs of the American Dental Association, July 1967

HEALTH • INSURANCE • COUNCIL

A.D.S. Form 5492

STATEMENT OF CLAIM

For Plan Dental Benefits

FILE NO. _____

INSTRUCTIONS: (1) Complete the Statement of Insured below. Have patient's physician complete the reverse side.

(2) Return form and attachments to the Group Policyholder.

PART 1. — **TO BE COMPLETED BY THE EMPLOYEE CLAIMING BENEFIT FOR SELF OR DEPENDENT**

1. Name of Employee	2. Social Security	3. Name of Employer

4. Address Number of Street City and State	5. Sex ☐ Male ☐ Female	6. Date of Birth	7. ☐ Married ☐ Single

8. Claim is made for (Check One) ☐ Self ☐ Spouse ☐ Unmarried child (10 days-18 years old) Unmarried Student (19 - 22 years old) attending _____
NAME OF HIGH SCHOOL OR UNIVERSITY

9. Name of Dependent for Whom Claim is Being Made	10. Date of Birth	11. Sex ☐ Male ☐ Female

12. Name of Spouse' s Employer	13. In your own words describe the nature of the sickness or injury

14. Are you or any other member of your family eligible to receive payment for this claim under any other insurance plan provided by any other group service or Government plan? ☐ Yes ☐ No If "Yes", answer below

15. A. Name of organization making payment	B. Address C. Amount Paid	

16. Name of person carrying other coverage	17. Policy No. & Certificate No.

18. Is this claim due to an accidental injury? ☐ Yes ☐ No if "Yes", A, B, C, D, E, and F must be answered

A. Was the accident due to injured person's occupation? ☐ Yes ☐ No	B. Date employed

C. Where was injured person when accident occurred? ☐ AM ☐ PM	D. Date of accident hour

E. What was injured person doing when accident occurred ?	F. How did accident occur?

I hereby certify that the foregoing statements, including any accompanying statements, are true and complete to the best of my knowledge. I hereby Authorize any physician, hospital, insurance company, organization or employer to release any information including full copies of their records to the THE PLAN ADMINISTRATOR for any medical treatment, services or benefits rendered or payable to me (or my dependents). A photostat of this authorization shall be as valid as the original.

Date _____ Signature of Insured _____ Signature of Patient _____
(Required only if Patient is Spouse)

Address of Covered Person _____
Street No. Town State Zip