SUBMIT COMPLETED FORM TO:

EMPLOYEE PLANS, LLC
P.O. Box 2362
Fort Wayne, IN 46801-2362

ATTENDING DENTIST'S STATEMENT

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

PATIENT NAME	RELATIONSHIP TO EMPLOYEE				SEX		PATIENT BIRTHDATE			IF FULL-TIME STUDENT	
	Self	Spouse	Child	Other	M	F	Mo.	Day	Year	School	City

EMPLOYEE NAME (FIRST, MIDDLE, LAST)	EMPLOYEE/SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY NUMBER
EMPLOYEE MAILING ADDRESS	EMPLOYER (COMPANY) NAME AND ADDRESS	
CITY, STATE, ZIP	GROUP NUMBER	

ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ NO ☐ YES IF YES, SOCIAL SECURITY # __________

NAME AND ADDRESS OF EMPLOYER OF OTHER FAMILY MEMBER __________

IS PATIENT COVERED BY OTHER DENTAL PLAN? ☐NO ☐YES IF YES, PLAN NAME __________ GROUP NUMBER __________

NAME AND ADDRESS OF CARRIER: __________

I HAVE REVIWED THE FOLLOWING TREATMENT PLAN I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.	I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
SIGNED (PATIENT OR PARENT IF MINOR) DATE	SIGNED (PATIENT OR PARNT IF MINOR) DATE

		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT?			
	OTHER ACCIDENT?			
CITY, STATE, ZIP	ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SOC SEC # OR TIN __________	IF PROTHESIS, IS THIS INITIAL PLACEMENT?			
LICENSE # __________	IF NO, REASON FOR REPLACEMENT			
PHONE # __________	DATE OF PRIOR PLACEMENT?			
FIRST VISIT DATE – CURRENT SERIES __________ PLACE OF TREATMENT ☐OFFICE ☐HOSP ☐ECF ☐OTHER	IS TREATMENT FOR ORTHODONTICS?			
RADIOGRAPHS OR MODELS ENCLOSED ☐ NO ☐ YES HOW MANY?	IF SERVICES ALREADY COMMENCED DATE APPLIANCES PLACED? MOS. OF TREATMENT REMAINING?			

IDENTIFY MISSING TEETH WITH "X"

Facial · Permanent · Lingual · Primary · Upper · Right · Left · Lower · Primary · Lingual · Permanent · Facial

EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH 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 MO	DAY	YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
						TOTAL FEE CHARGED		
						MAX. ALLOWABLE		
						DEDUCTIBLE		

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.	CARRIER %	
	CARRIER PAYS	
SIGNED (DENTIST) DATE	PATIENT PAYS	