ATTENDING DENTIST STATEMENT

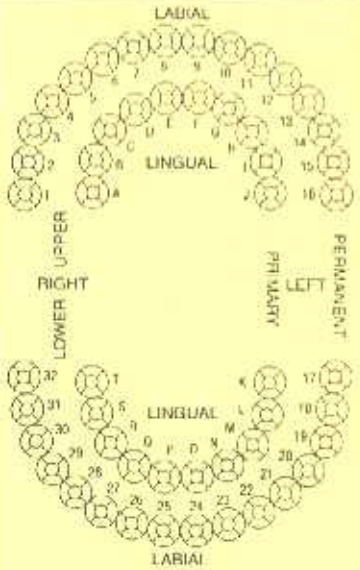
☐ DENTIST'S PRETREATMENT ESTIMATE - SUBMIT RADIOGRAPHS WHEN APPROPRIATE

☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES - MUST BE RECEIVED WITHIN 90 DAYS OF DATE OF SERVICE**

1. Patient's Name – First	MI	Last	2. Birth Date (Mo/Day/Yr)	3. Patient's Soc. Sec. No. — —
4. Address – Street	City	State	Zip Code	5. Relation to Employee ☐ Self ☐ Spouse ☐ Dependent Child

6. DENTIST NAME FIRST MI LAST	14. IS TREATMENT RESULT OF	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
7. MAILING ADDRESS STREET	OCCUPATIONAL ILLNESS OR INJURY?			
	AUTO ACCIDENT?			
CITY STATE ZIP CODE	OTHER ACCIDENT?			
	15. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			IF YES, NAME OF OTHER PLAN
8. DENTIST EIN (9 digits) / SOC. SEC. NO. — —	16. IF PROSTHESIS, IS THIS INITIAL PLACEMENT			(IF NO, REASON FOR REPLACEMENT) / DATE OF PRIOR PLACEMENT
9. DENTIST LICENSE NO / 10. DENTIST PHONE NO				
11. FIRST VISIT DATE CURRENT SERIES / 12. PLACE OF TREATMENT ☐ OFFICE ☐ HOSP. ☐ FDF ☐ OTHER / 13. RADIOGRAPHS OR MODELS ENCLOSED? ☐ YES ☐ NO / HOW MANY?	17. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

EXAMINATION AND TREATMENT RECORD – USE CHARTING SYSTEM SHOWN – List in order from tooth no. 1 to tooth no. 32



INDICATE MISSING TEETH WITH AN "X"

TOOTH # OR LETTER	SURFACES (M O D B L I J K)	DESCRIPTION OF SERVICE (including x-rays, prophylaxis, materials used, etc.)	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE	DO NOT USE THIS COLUMN

I hereby certify that the procedures as indicated by "date service performed" have been completed and the fees indicated are those actually charged or will be charged the patient.

TOTAL FEE CHARGED

DENTIST SIGNATURE / DATE

I have reviewed the foregoing treatment plan and/or statement of services. I agree with the services and charges shown and authorize any information relating to this claim to be released to the Plan Administrator or other authorized agent of the Fund for the purpose of validating and determining benefits payable in connection with this claim.

PATIENT SIGNATURE (Parent or guardian if claim is for a minor child)

DATE

IMPORTANT

ASSIGNMENT OF BENEFITS – COMPLETE ONLY IF BENEFITS WILL BE ACCEPTED AS PAYMENT IN FULL. THE FUND OFFICE WILL GIVE PROMPT SERVICE AND PRIORITY OF PAYMENT TO ASSIGNED CLAIMS.

DENTIST – I agree to accept the Fund's benefits as payment in full for covered services. I will not bill the member for any balance amount due on any covered service.

Dentist Signature _____ Date _____

MEMBER – I authorize payment directly to the above named dentist of the dental benefits otherwise payable to me. I understand the dentist has agreed to accept the FUND'S payment as payment in full for covered services.

Employee Signature _____ Date _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT. THIS IS A CRIME.