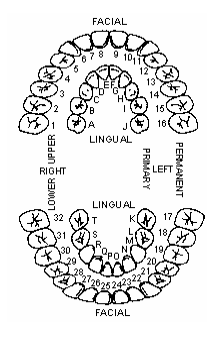


ATTENDING DENTIST'S STATEMENT

EMPLOYEE PART A	1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE SELF, SPOUSE, CHILD, OTHER		3. SEX M, F	4. PATIENT BIRTHDATE MONTH, DAY, YEAR		5. IF FULL-TIME STUDENT SCHOOL CITY			
	6. EMPLOYEE NAME FIRST MIDDLE LAST			7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NUMBER			8. EMPLOYEE/SUBSCRIBER BIRTHDATE MONTH, DAY, YEAR				
	EMPLOYEE MAILING ADDRESS				9. EMPLOYER (COMPANY) NAME AND ADDRESS						
	CITY, STATE, ZIP				10. GROUP NO.						
11. IS PATIENT COVERED BY ANOTHER BENEFIT PLAN? <input type="checkbox"/> NO <input type="checkbox"/> YES			EMPLOYER (COMPANY) OR PLAN NAME		GROUP NO.		12. NAME AND ADDRESS OF CARRIER(S)				
13. EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)		EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NUMBER		BIRTHDATE MONTH DAY YEAR		RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		14. DATE OF ACCIDENT MONTH, DAY, YEAR		HOW DID ACCIDENT HAPPEN?	
15A. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. MY DENTIST MAY GIVE CMS INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR THE DURATION OF THIS CLAIM. I KNOW THAT I AM ENTITLED TO A COPY OF THIS AUTHORIZATION.						15B. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST FOR THE SERVICES DESCRIBED BELOW					
SIGNED (PATIENT OR PARENT IF MINOR)						DATE		SIGNED (EMPLOYEE OR AUTHORIZED PERSON)			DATE

IMPORTANT: For X-Ray submission, see instructions on reverse side.

16. DENTIST NAME			24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES		
17. MAILING ADDRESS			25. IS TREATMENT RESULT OF AUTO ACCIDENT?						
CITY, STATE, ZIP			26. OTHER ACCIDENT?						
18. DENTIST SOC. SEC. OR T.I.N.			19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?		
21. FIRST VISIT DATE			22. PLACE OF TREATMENT OFFICE, HOSP, ECF, OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED?		NO	YES	HOW MANY?
28. IF PROTHESIS, IS THIS INITIAL PLACEMENT?			29. DATE OF PRIOR PLACEMENT		30. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED. ENTER DATE APPLICANCE PLACED _____ MOS. TREATMENT REMAINING _____		

<p>PART B</p> <p><input type="checkbox"/> Pre-treatment Estimate (date)</p> <p><input type="checkbox"/> Statement of Actual Services</p>  <p>Indicate Missing Teeth With An "X"</p>	31. 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) COMPLETION OF TOOTH CHART IS REQUIRED	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE				
							Does this plan have a direct pay provision?			
							<input type="checkbox"/> Yes <input type="checkbox"/> No			
32. I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE FEES I USUALLY CHARGE AND ACCEPT FOR SUCH PROCEDURES.						TOTAL FEE CHARGED				
SIGNED DENTIST						AMOUNT PAID BY PATIENT				
DATE						BALANCE DUE				

Future plan benefits, as well as those indicated, will be payable if the services listed above are performed while this patient is covered under this plan, subject to plan provisions and coordination of benefits with other Group Plans. The plan administrator does not insure benefits under your Employer Group Plan. Your Employer is solely responsible for determination of entitlement to, and payment of, any amounts due under the Plan.

HOW TO FILE A CLAIM FOR DENTAL BENEFITS

The Employee should complete Part A in full before taking the form to the dentist. This will assure proper identification and prompt payment.

The patient (or parent, if patient is a minor) must sign the "Authorization to Release Information," question 15A.

Part B will be completed by the dentist after his/her examination of the patient. The box labeled "Statement of Actual Services" will be checked after treatment has been done and certification (Item 32) has been signed.

PAYMENT WILL BE MADE DIRECTLY TO THE DENTIST PROVIDED ITEM 15B IN PART A HAS BEEN SIGNED BY THE PATIENT OR IF THE PATIENT'S PLAN AUTOMATICALLY PROVIDES FOR SUCH PAYMENT.

PRE-STATEMENT

IF YOU ANTICIPATE EXTENSIVE DENTAL WORK, YOU MAY SUBMIT A REQUEST FOR A PRE-DETERMINATION ESTIMATE OF BENEFITS AS DESCRIBED IN YOUR BOOKLET.

- a) For a pre-determination of benefits, the dentist will check the box in Part B labeled "Pre-treatment Estimate" and complete Part B after examination of the patient. The dentist will return the form to the address shown on the front.
- b) The dentist will receive an Explanation of Benefits (EOB) from the Claims Department outlining benefit estimate.
- c) The dentist will review the treatment plan with the patient.
- d) Upon completion of treatment, the dentist certifies that treatment has been done and mails the EOB to the Group Dental Claim Office address shown on the front of that form. Upon receipt, the claim will be reviewed and benefits issued.

X-RAY SUBMISSION

X-rays are required only when the procedure codes submitted are for crowns, partials and/or fixed bridges or when a direct request is made. Please indicate the patient's name, group number and provider's name and address on each x-ray.

COMPLETION OF THE TOOTH CHART

Indicate missing teeth with an "X" as instructed in Part B.