Reset

The Standard Life Insurance Company of New York

Group Dental Insurance 888.396.8641 Tel 402.467.7336 Fax
PO Box 82520 Lincoln NE 68501

Attending Dentist's Statement Treatment Plan and Insurance Claim Report

Please check appropriate box: ☐ Dentist's pre-treatment estimate of charges ☐ Dentist's statement of actual charges

TO BE COMPLETED BY EMPLOYEE

1. Patient's Name	2. Social Security No.	3. If full time student, please provide name of school:
4. Sex ☐ Male ☐ Female	5. Patient's Birthdate	6. Relationship to Employee ☐ Self ☐ Spouse ☐ Child
7. Employee/Subscriber's name and mailing address: *(city, state, zip code)*		
8. Employer's (Company) name and mailing address: *(city, state, zip code)*		
9. Is patient covered by another Dental Plan? ☐ Yes ☐ No	If Yes, please provide the dental carrier's name and address: *(city, state, zip code)*	

If payment is to be made to provider, please sign below.

AUTHORIZATION TO PAY BENEFITS TO PROVIDERS

I hereby authorize payment of benefits to any providers of service, otherwise payable to me for services but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

Signature of Insured Person

Date

Patient or Parent please sign below.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I authorize The Standard to release information about me to any person/entity performing services in connection with the administration of the dental plan. I hereby certify the information provided is correct and true to the best of my knowledge.

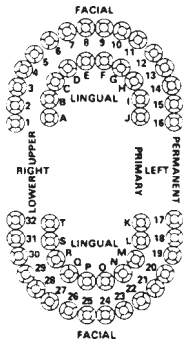
I understand this authorization shall remain inforce for one year. I understand that I have the right to revoke the authorization at any time by sending a statement to The Standard, and that a revocation of the authorization, or failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim. Revocation of the authorization may be a basis for denying my claim for benefits.

Signature of Patient *(or parent if patient is a minor)* Date

TO BE COMPLETED BY DENTIST

Dentist Name:		Dentist Social Security No. or TIN:		Dentist License No.:
Mailing Address:	City:	State:	Zip:	Dentist Phone No.:
First Visit Date *(current series):*	Office:	Place of Treatment: ☐ Hosp. ☐ ECF ☐ Other		Radiographs or Models Enclosed? ☐ Yes ☐ No How Many? _____
Is treatment result of occupational illness or injury? ☐ Yes ☐ No		If yes, enter brief description and dates.		
Is treatment result of auto accident? ☐ Yes ☐ No Other accident? ☐ Yes ☐ No				
Are any services covered by another plan? ☐ Yes ☐ No				
If crown or prothesis, is this initial placement? ☐ Yes ☐ No		If no, reason for replacement.		Date of Prior Placement:
Is treatment for orthodontics? ☐ Yes ☐ No		If service already commenced, please enter the date appliance was placed, and the number of months of treatment remaining. Date: _____ No. Mos.: _____		

Identify Missing Teeth with "X"



Remarks for Unusual Services

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 Yr	Procedure Number	Fee	For Administrative Use Only

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

▶ _____ _____
Signature of Dentist Date

TOTAL FEE CHARGED:	
Max. Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	

Print (6/05)