

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Patient's Birthdate	6. Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	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 in force 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 Insured Person	Signature of Patient (or parent if patient is a minor)	
Date	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: <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other Radiographs or Models Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No How Many? _____																
Is treatment result of occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, enter brief description and dates.																	
Is treatment result of auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
Other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
Are any services covered by another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
If crown or prosthesis, is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, reason for replacement.	Date of Prior Placement:																
Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> 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"	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											
Remarks for Unusual Services	<table border="1"> <tr> <td>TOTAL FEE CHARGED:</td> <td></td> </tr> <tr> <td>Max. Allowable</td> <td></td> </tr> <tr> <td>Deductible</td> <td></td> </tr> <tr> <td>Carrier %</td> <td></td> </tr> <tr> <td>Carrier Pays</td> <td></td> </tr> <tr> <td>Patient Pays</td> <td></td> </tr> </table>						TOTAL FEE CHARGED:		Max. Allowable		Deductible		Carrier %		Carrier Pays		Patient Pays	
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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														