CHECK ONE: ☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

ORGANIZATION

1. PATIENT NAME:

2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER

3. SEX: M | F

4. PATIENT BIRTHDATE: MO. | DAY | YEAR

5. IF FULL TIME STUDENT: SCHOOL | CITY

6. EMPLOYEE/SUBSCRIBER NAME: First Middle Last

7. EMPLOYEE SOC. SEC. NO.

8. EMPLOYER (COMPANY) NAME AND ADDRESS

9. EMPLOYEE/SUBSCRIBER MAILING ADDRESS

CITY, STATE, ZIP

ELIGIBILITY DATE

CARD NUMBER

APPROVAL DATE

10. GROUP NO.

11. IS SPOUSE EMPLOYED? ☐ YES ☐ NO

Employee Name | Soc. Sec. No. | Date of Birth

12. NAME AND ADDRESS OF EMPLOYER IN ITEM 11

13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?

DENTAL PLAN NAME | UNION LOCAL | GROUP NO. | NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT, OR PARENT IF MINOR) | DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (INSURED PERSON) | DATE

14. DENTIST NAME | DR. CODE

15. MAILING ADDRESS

CITY, STATE, ZIP

16. DENTIST (Soc. Sec. or TIN) | 17. DENTIST LIC. NO. | 18. DENTIST PHONE NO.

19. Is Treatment Result of Occupational Illness or Injury? NO YES IF YES, ENTER BRIEF DESCRIPTION & DATES

20. Is Treatment Result of Auto Accident?

21. Other Accident?

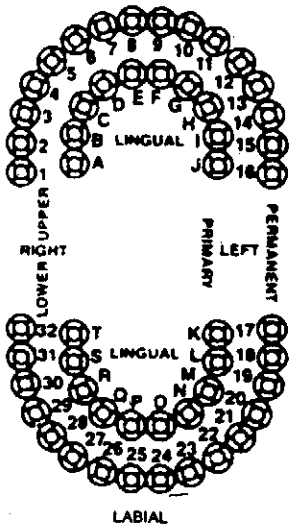
22. Are Any Services Covered by Another Plan?

23. If Prosthetics, is this initial Placement? (If NO, reason for replacement) | 25. Date of Prior Placement

REMARKS FOR UNUSUAL SERVICES

D.D.S. INFO

INDICATE MISSING TEETH WITH AN "X"



EXAMINATION AND TREATMENT RECORD-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

TOOTH NO. LETTER/ QUAD	SUR-FACES	(INCLUDING X-RAYS, PROPHLAXIS MATERIAL USED, ETC.)	DATE SERVICE PERFORMED MO.	DAY	YR.	ADA PROCEDURE NUMBER	FEE	FOR ADMINIS-TRATIVE USE ONLY	CO-PAY

If the treatment exceeds $300.00 then this form and the patient's x-rays must be sent to the address below for pre-authorization. Pre and post op x-rays required on all unauthorized root canals

TOTAL

Date

Previous Utilization

Total Fees Covered

Patient Pays

Approved

Approved With Limitation

Disapproved

Approved By

PREVIOUS UTILIZATION TO DATE	
AMOUNT BILLED YEAR	
DEDUCTIBLE	
PATIENT PAYS	

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE OF SERVICES, HAVE BEEN PERFORMED

SIGNED (Dentist)

DATE

Benefits will be paid, provided that members insurance is in force at the time services are rendered, and subject to coordination of benefits, limitations and exclusions and remaining maximum at the time of submission for payments.

® GCU 247-C

REMOVE ALL X-RAYS WHEN SUBMITTING FOR PAYMENT ON AUTHORIZED WORK.

MAIL CLAIM FORMS TO: DDS., INC. 1640 HEMPSTEAD TURNPIKE, EAST MEADOW, NY 11554-1040 (516) 794-7700