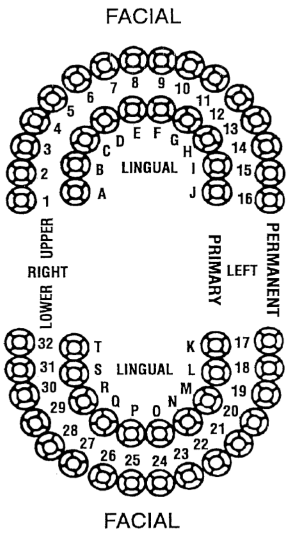
# ATTENDING DENTIST'S STATEMENT

Great Neck Teachers Association Benefit Trust Fund
C/O THE PREFERRED GROUP
P.O. Box 15136
Albany, NY 12212-5136
(518) 591-4965 • FAX: (518) 641-0325 • (866) 989-8997

CHECK ONE
☐ DENTIST'S PRE-TREATMENT ESTIMATE*
***REQUIRED FOR TREATMENT OVER $500**
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

| | | | |
|---|---|---|---|
| 1. EMPLOYEE NAME | SS# | 2. ELIGIBILITY VERIFIED BY | |
| 3. ADDRESS | CITY | STATE OR PROVINCE | ZIP |
| 4. PATIENT NAME (IF A DEPENDENT) | RELATIONSHIP TO EMPLOYEE | 6.BIRTHDATE | 7. STUDENT STATUS YES ☐ NO ☐ |
| 8. EMPLOYER NAME **GREAT NECK TABTF** | GROUP NUMBER | 9. DOES THE PATIENT HAVE OTHER DENTAL COVERAGE? YES ☐ NO ☐<br>IF "YES" PLEASE IDENTIFY | |
| 10. GROUP DENTAL PLAN NAME | | 11. PLAN NUMBER | |
| 12. DENTISTS NAME (PRINT) | 13. LICENSE NO. | 14. INDIVIDUAL PRACTITIONERS SS # _____-___-_______ | |
| 15. ADDRESS / CITY | STATE OR PROVINCE / ZIP | ALL OTHERS - EMPLOYER T.I.N. # ______-_____________<br>***MUST BE FURNISHED UNDER AUTHORITY OF LAW** | |
| 16. IS ANY OF THE TREATMENT FOR: (A) ORTHODONTIC PURPOSE? YES ☐ NO☐ | (B) ACCIDENTAL INJURY? YES ☐ NO ☐ | (C) OCCUPATIONAL INJURY? YES ☐ NO ☐ | |
| 17. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? YES ☐ NO☐<br>IF "NO", REASON FOR REPLACEMENT | 18. DATE OF PRIOR PLACEMENT | ARE X-RAYS ENCLOSED? YES ☐ NO☐<br>IF "YES", HOW MANY? | |

FACIAL




FACIAL

INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES

X-Rays may be requested for certain services.

EXAMINATION AND TREATMENT RECORD - USE CHARTING SYSTEM SHOWN

| TOOTH # OR LETTER | SURFACES | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.) | DOS MO | DOS DY | DOS YR | ADA PROCEDURE NUMBER | FEE | FOR OFFICE USE ONLY |
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| | | | | | | TOTAL FEE CHARGED | | |
| | | | | | | DEDUCTIBLE | | |
| | | | | | | BALANCE | | |

For pre-treatment estimates, proposed treatment should be submitted exclusive of dates. Form will be returned reflecting Benefits Payable. When work is completed, form should be resubmitted reflecting dates of service.

Predetermined benefits valid only if services performed while patient's insurance is in force.

I HAVE REVIEWED THE FOREGOING TREATMENT PLAN, I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

SIGNED (PATIENT) ______________________ DATE ______________

I HEREBY CERTIFY THAT THAT THE SERVICES LISTED ABOVE ☐ WILL BE ☐ HAVE BEEN PERFORMED

SIGNED (DENTIST) ______________________ DATE ______________

I hereby authorize payment to the above named Dentist of the benefits payable, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization, or incurred when my insurance is no longer in effect.

SIGNED (insured) ______________________ DATE ______________