ATTENDING DENTIST'S STATEMENT

Great Neck Teachers Association Benefit Trust Fund
C/O Dickinson Group, LLC
50 Charles Lindbergh Blvd. Suite 207
Uniondale, NY 11553
Phone 877-347-7225, E-mail GNSC@DickinsonGrp.com
Fax 516-740-5417

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 ☐ IF "YES" PLEASE IDENTIFY

10. GROUP DENTAL PLAN NAME	11. PLAN NUMBER

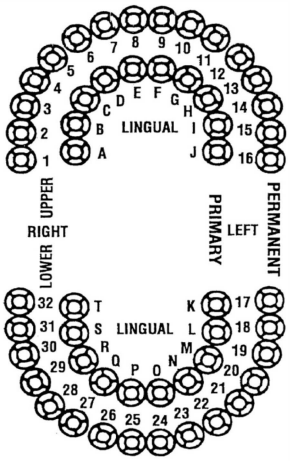
12. DENTISTS NAME (PRINT)	13. LICENSE NO.	14. INDIVIDUAL PRACTITIONERS SS # ____-___-_____

15. ADDRESS	CITY	STATE OR PROVINCE	ZIP	ALL OTHERS - EMPLOYER T.I.N. # _____-_____
				***MUST BE FURNISHED UNDER AUTHORITY OF LAW**

16. IS ANY OF THE TREATMENT FOR: (A) ORTHODONTIC PURPOSE?	(B) ACCIDENTAL INJURY?	(C) OCCUPATIONAL INJURY?
YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

17. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? YES ☐ NO ☐ IF "NO", REASON FOR REPLACEMENT	18. DATE OF PRIOR PLACEMENT	ARE X-RAYS ENCLOSED? YES ☐ NO ☐ 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

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.

TOTAL FEE CHARGED		
DEDUCTIBLE		
BALANCE		

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 _____