

ATTENDING DENTIST'S STATEMENT



SM

Please send completed form to:
 SIEBA, LTD.
 Group 195D
 111 Grant Ave, Ste 202
 PO Box 5000
 Endicott, NY 13761-5000
 FAX 607-786-3378

DENTIST SHOULD CHECK ONE

PRE-TREATMENT ESTIMATE

DENTIST'S STATEMENT OF ACTUAL SERVICES

EMPLOYEE SHOULD COMPLETE

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX MALE FEMALE		4. PATIENT BIRTHDATE MONTH DAY YEAR		
6. EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST			7. EMPLOYEE/SUBSCRIBER IDENTIFIER (SSN or ID#)			9. NAME OF GROUP DENTAL PROGRAM Eden II Schools Group Dental Plan		
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS						10. EMPLOYER (COMPANY) NAME AND ADDRESS Eden II Schools For Autistic Children 150 Granite Ave Staten Island, NY 10303		
CITY, STATE, ZIP			13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME IDENTIFIER (SSN or ID#)			14. NAME AND ADDRESS OF EMPLOYER ITEM 13		
COMPLETE 13-15 IF COVERED BY ANOTHER DENTAL PLAN			15. 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. X				I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST. XX				
SIGNED (PATIENT OR PARENT IF MINOR) _____				DATE _____				
				SIGNED (EMPLOYEE) _____				
				DATE _____				

16. DENTIST NAME				24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
17. MAILING ADDRESS				25. IS TREATMENT RESULT OF AUTO ACCIDENT?				
CITY, STATE, ZIP				26. OTHER ACCIDENT?				
18. DENTIST SOC. SEC. OR T.I.N.				19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?
21. FIRST VISIT DATE CURRENT SERIES				22. PLACE OF TREATMENT OFFICE HOSP ECF OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?		29. IS TREATMENT FOR ORTHODONTICS?
								(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
								IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED MOS TREATMENT REMAINING

DENTIST SHOULD COMPLETE

Identify Missing Teeth with 'X' FACIAL FACIAL 32. REMARKS FOR UNUSUAL SERVICES	31. EXAMINATION AND TREATMENT PLAN, LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN						FOR ADMINISTRATIVE USE ONLY
	TOOTH # OR LETTE	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS, USED, ETC.)	DATE OF SERVICE PERFORMED	PROCEDURE NUMBER	FEE	
	1						
	2						
	3						
	4						
	5						
	6						
	7						
	8						
	9						
	10						
	11						
	12						
	13						
	14						
15							
16							

SIGNATURE OF DENTIST OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS). I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT I PERSONALLY RENDERED THE ABOVE SERVICES AND THAT ALL CHARGES SHOWN REPRESENT MY USUAL CHARGE. X				TOTAL FEE CHARGED	
SIGNED (DENTIST) _____					
DATE _____					

DOCTOR: We encourage your seeking a pre-treatment estimate on work expected to cost \$150 or more. If you have any questions about pre-treatment or any other aspect of this Dental Assistance Plan, please feel free to call SIEBA, LTD. at (607) 786-3003 or (800) 252-4624. FAX 607-786-3378.