DENTAL PLAN BENEFIT REQUEST FORM

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

PATIENT INFORMATION

1. PATIENT NAME (FIRST MIDDLE INITIAL LAST)
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 NAME: FIRST | MIDDLE INITIAL | LAST
7. EMPLOYEE SOCIAL SECURITY NO.
8. EMPLOYEE ADDRESS
   CITY, STATE, ZIP | TELEPHONE #
9. GROUP NAME (E.G. EMPLOYER)
10. EMPLOYER ADDRESS
11. GROUP NUMBER
12. LOCATION (LOCAL)
13. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO
    IF YES: EMPLOYEE NAME | SOC. SEC. NO.
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO
    IF YES, GIVE: GROUP NAME | UNION LOCAL | GROUP NO. | NAME AND ADDRESS OF PROVIDER OF BENEFITS

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS REQUEST.

▶ ______________________ SIGNED (PATIENT, OR PARENT IF MINOR) ________ DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST FOR THE SERVICES DESCRIBED BELOW.

▶ ______________________ SIGNED (EMPLOYEE OR AUTHORIZED PERSON) ________ DATE

DENTIST'S INFORMATION

16. DENTIST NAME
17. MAILING ADDRESS
    CITY, STATE, ZIP
18. DENTIST SOC. SEC. OR T I N
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) — 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH X

FACIAL — UPPER: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16; PRIMARY: A B C D E F G H I J — LINGUAL — RIGHT / LEFT — PERMANENT / PRIMARY — LOWER: 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32; PRIMARY: K L M N O P Q R S T — LINGUAL — 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.

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

▶ ______________________ SIGNED (DENTIST) DATE ________

TOTAL FEE CHARGED	
Plan Maximum	
Payable Now	

ESTIMATED ADDITIONAL BENEFIT when treatment is completed.	

Form Approved by the Council on Dental Care Programs of the A.D.A. 1975

FORM DP-1 REV. 8/88