

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.		9. GROUP NAME (E.G. EMPLOYER)				
8. EMPLOYEE ADDRESS CITY, STATE, ZIP					10. EMPLOYER ADDRESS TELEPHONE #				
11. GROUP NUMBER	12. LOCATION (LOCAL)	13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME SOC. SEC. NO. <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES			14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.				
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE		GROUP NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF PROVIDER OF BENEFITS				

<p>I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS REQUEST.</p> <p>▶ _____ SIGNED (PATIENT, OR PARENT IF MINOR) DATE _____</p>	<p>I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST FOR THE SERVICES DESCRIBED BELOW.</p> <p>▶ _____ SIGNED (EMPLOYEE OR AUTHORIZED PERSON) DATE _____</p>
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16. DENTIST NAME				24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES IF YES, ENTER BRIEF DESCRIPTION AND DATES	
17. MAILING ADDRESS CITY, STATE, ZIP				25. IS TREATMENT RESULT OF AUTO ACCIDENT?	
18. DENTIST SOC. SEC. OR T I N				26. OTHER ACCIDENT?	
19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	
21. FIRST VISIT DATE CURRENT SERIES		22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER		28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	
23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?		29. DATE OF PRIOR PLACEMENT		IF SERVICES ALREADY COMMENCED. ENTER DATE APPLICANCES PLACED NOS. TREATMENT REMAINING	

DENTIST'S INFORMATION

<p>IDENTIFY MISSING TEETH WITH X</p> <p>22. REMARKS FOR UNUSUAL SERVICES</p>	<p>31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">TOOTH # OR LETTER</th> <th rowspan="2">SURFACE</th> <th rowspan="2">DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.</th> <th colspan="3">DATE SERVICE PERFORMED</th> <th rowspan="2">PROCEDURE NUMBER</th> <th rowspan="2">FEE</th> <th rowspan="2">FOR ADMINISTRATIVE USE ONLY</th> </tr> <tr> <th>MO.</th> <th>DAY</th> <th>YEAR</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td>1</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>2</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>3</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>4</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>5</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>6</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>7</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>8</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>9</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>10</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>11</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>12</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>13</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>14</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>15</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED			PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY	MO.	DAY	YEAR			1									2									3									4									5									6									7									8									9									10									11									12									13									14									15						
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<p>I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.</p> <p>▶ _____ SIGNED (DENTIST) DATE _____</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>TOTAL FEE CHARGED</td> <td> </td> </tr> <tr> <td>Plan Maximum</td> <td> </td> </tr> <tr> <td>Payable Now</td> <td> </td> </tr> </table>	TOTAL FEE CHARGED		Plan Maximum		Payable Now	
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ESTIMATED ADDITIONAL BENEFIT when treatment is completed.

I.E. SHAFFER & Co.

830 Bear Tavern Road, West Trenton, NJ 08628-1020

Mailing Address:

PO Box 1028, Trenton NJ 08628-0230

(609) 883-6688

(800) 792-3666

Fax (609) 530-1331

HOW TO REQUEST DENTAL PLAN BENEFITS



EMPLOYEE

1. Complete items 1 - 15 on the attached form and sign your name. If you wish your benefits paid directly to your dentist, also sign the payment authorization.
2. Ask the dentist to complete items 16 - 32. If the charges are only for examinations, cleanings or X-rays, itemized bills may be submitted instead of the dentist's portion of the form. Each bill submitted must show the patient's name, relationship, date of service and nature of service. If this information is missing, write it on the bill yourself and sign your name.
3. Please be sure you have provided your Social Security Number (item 7).
4. The completed "Benefit Request Form" should be submitted directly to I.E. Shaffer & Co.

IF YOU ANTICIPATE EXTENSIVE DENTAL WORK, YOU MAY SUBMIT A REQUEST FOR A PRE-TREATMENT ESTIMATE OF BENEFITS AS DESCRIBED IN YOUR BOOKLET.



DENTIST

1. Complete items 16 - 32 on the Benefit Request Form using the ADA codes and nomenclature listed on the reverse side of this sheet. Indicate whether the form represents a request for a pre-treatment estimate or is a statement of services actually rendered.
2. If for a pre-treatment estimate, leave the date blank for those services that have not been completed. Our estimate and your X-rays will be returned to you promptly. Estimates are made taking into consideration plan provisions and are based on the assumption that the patient will receive the services while covered and the treatment plan does not change. Actual payment may differ from the estimate.
3. When you complete treatment, please return the same form to us with the treatment dates indicated on it. Please describe any change in the treatment plan.

NOTE: In order to expedite payment it is suggested that PRE-TREATMENT X-RAYS be submitted along with the Benefit Request Form when the course of treatment includes gold restorations, crowns or bridgework. X-rays may also be requested for other services.