IMPORTANT:

"Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."

PLEASE REVIEW BEFORE SUBMITTING CLAIMS

INSTRUCTIONS FOR MEMBERS:

1. Complete items 1 through 15 in full to assure positive and prompt payment. Please print or type.
2. The member must sign and date the claim.
3. If total charges for the planned course of treatment can reasonably be expected to be $250 or more, the form must be completed and submitted prior to the commencement of the course of treatment for a predetermination of benefits. Healthplex will notify you of the benefits payable. X-RAYS MUST BE ATTACHED.
4. If total charges for the planned course of treatment will be less than $250, the claim form should be completed when treatment is completed.
5. Dental coverage is subject to specific limitations and exclusions. Please refer to your insurance booklet and certificate for a description of covered services, limitations, and exclusions.
6. THIS FORM WILL BE RETURNED IF IT IS INCOMPLETE OR INCORRECT.

INSTRUCTIONS FOR DENTIST:

Predetermination required for $250 or more, x-rays must be attached.

Claim settlements will be issued directly to the employee/member. Assignment of benefits will not be honored without employee/member authorized signature.

Generally, x-rays will not be required pre-operatively when the treatment plan involves only the use of Amalgam, Plastic, Silicate or Composite Restorations.

Diagnostic x-rays should be submitted for all other treatment. A pre-operative and post-operative x-ray is required where endodontic treatment has been rendered.

REMARKS FOR UNUSUAL SERVICES

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F-2098 Print 6/04

Healthplex
333 Earle Ovington Boulevard
Suite 300
Uniondale, NY 11553-3608

516-542-2200 800-468-0600
www.healthplex.com E-Mail info@healthplex.com

[ ] Pre Treatment Estimate
[ ] Statement of Actual Services

1. Patient Name	2. Relationship to Subscriber Self Spouse Child Other	3. Sex M F	4. Patient Birthdate	5. Fulltime Student School City
6. Subscriber Name First Middle Last	7. Subscriber Social Security Number		8. Subscriber Date of Birth	
9. Subscriber Mailing Address	City, State, Zip			
10. Group No.	11. Are Other Family Members Employed? Employee Name Soc. Sec. No.	12. Date of Birth	13. Name and Address of Employer in Item 11	
14. Is Patient Covered by Another Dental Plan?	15. Dental Plan Name	Policy #	Name and Address of Carrier	

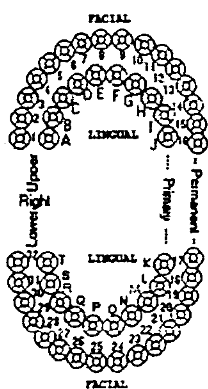
I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.	I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP BENEFITS OTHERWISE PAYABLE TO ME:
Signed (Patient, or Parent if Minor) Date	Signed (Insured Person) Date

To Be Completed By Dentist

16. Dentist Name				24. Is Treatment Result of Occupational Illness Or Injury?	No	Yes	IF Yes, Give Brief Description and Dates
17. Mailing Address				25. Is Treatment Result of Auto Accident? 26. Other Accident?			
City, State, Zip				27. Are Any Services Covered By Another Plan?			
18. Dentist(Soc.Sec. Or T.I.N.) 19. Dentist License # 20. Dentist Phone #				28. If Prosthesis, Is This Initial Placement?			(If No Reason For Replacement) 29. Date of Prior Placement
21. First Visit Date Current Series 22. Place of Treatment Office/Hosp/ECF/Other 23. Radiographs Or Models Enc.?	No	Yes	How Many?	30. Is treatment for Orthodontics?			If Services Already Commenced Enter Date Appliances Placed Mos Tx Remaining?

31. Examinations and Treatment Plan - List In Order From Tooth No. 1 Through Tooth No. 32. - Use Charting System Shown

Identify Missing Teeth with "X"



Tooth # or Letter	/ Surface	Description of Service (Including X-Rays, Prophylaxis, Materials used, etc.) Line No.	Date Service Performed Mo Day Yr	Procedure Number	Fee	For Administrative Use Only
		1.				
		2.				
		3.				
		4.				
		5.				
		6.				
		7.				
		8.				
		9.				
		10.				
		11.				
		12.				
		13.				
		14.				

I Hereby Certify That The Procedures As Indicated By Date Have Been Completed

Total Fee Charged________________

_______________________________________ Date______________________
(Signed - Dentist)