



**AMERICAN  
GENERAL**

**Attending Dentist's Statement**

**The United States Life Insurance Company in the City of New York**

New York, New York

A member company of American International Group, Inc.

Return Claim to: P.O. Box 1581, Neptune, NJ 07754-1581

<b>P A T I E N T  S E C T I O N</b>	<b>Check One:</b> <input type="checkbox"/> <b>Dentist's pre-treatment estimate</b> <input type="checkbox"/> <b>Dentist's statement of actual services</b>										
	1. Patient name First                      M.I.                      Last			2. Relationship to Employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____		3. Sex M    F		4. Patient birthdate MO    DAY    YR		5. If full-time student School                      City	
	6. Employee/Subscriber name and mailing address			7. Insured's ID #		8. Employee/Subscriber birthdate MM    DD    YYYY		9. Employer (Company) Name and Address		10. Group Number	
	11. Is Patient covered by another plan of benefits? Dental _____ Medical _____			12-A. Name and address of carrier(s)			12-B. Group no.(s)		13. Name and Address of employer		
14-A. Employee/Subscriber name (if different than patient's)			14-B. Employee/Subscriber Soc. sec. number		14-C. Employee/Subscriber birthdate MO    DAY    YR		15. Relationship to Patient <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____				

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

▶ \_\_\_\_\_ Date \_\_\_\_\_

**DENTIST SECTION**

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.	
21. First visit date current series.			22. Place of treatment Office    Hosp.    ECF.    Other		23. Radiographs or models enclosed? No    Yes    How many?	
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, Date appliances placed. Mos. treatment remaining?	

<p>Identify missing teeth with "x"</p> <p>32. Remarks for unusual services</p>	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 letter	Surface	Description of service (Including x-rays, prophylaxis, materials used, etc.) Line No.	Date service performed mo. day year	Procedure number	Fee	
	1			/ /			
	2			/ /			
	3			/ /			
	4			/ /			
	5			/ /			
	6			/ /			
	7			/ /			
	8			/ /			
	9			/ /			
	10			/ /			
	11			/ /			
	12			/ /			
	13			/ /			
	14			/ /			
	15			/ /			
	16			/ /			
	17			/ /			
	18			/ /			
	19			/ /			
20			/ /				

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures

▶ \_\_\_\_\_ Date: \_\_\_\_\_

Signed (Dentist)

<b>Total Fee Charged</b>	
Max. Allowable	
Deductible	
Carrier #	
Carrier pays	
Patient pays	