

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

New York, New York

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

PATIENT SECTION	Check One:										
	<input type="checkbox"/> Dentist's pre-treatment estimate					<input type="checkbox"/> Dentist's statement of actual services					
	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.

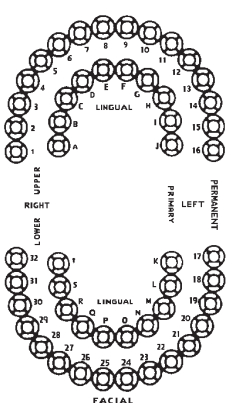
Signed (Patient, or parent if minor) _____ Date _____

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

Signed (Insured person) _____ 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.		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?		27. Are any services covered by another plan?	
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" 	31. Examination and treatment plan — list in order from tooth no. 1 through tooth no. 32 — use charting system shown. <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Tooth # or letter</th> <th style="width: 10%;">Surface</th> <th style="width: 40%;">Description of service (Including x-rays, prophylaxis, materials used, etc.) Line No.</th> <th style="width: 10%;">Date service performed mo. day year</th> <th style="width: 10%;">Procedure number</th> <th style="width: 10%;">Fee</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>7</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>8</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>9</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>10</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>11</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>12</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>13</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>14</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>15</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>16</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>17</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>18</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>19</td><td></td><td></td><td>/ /</td><td></td><td></td></tr> <tr><td>20</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 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			/ /			For administrative use only
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32. Remarks for unusual services																																																																																																																																

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

Signed (Dentist) _____ Date: _____

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier #	
Carrier pays	
Patient pays	