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
EMPLOYEE NAME, SOC. SEC. NO.
IF YES

14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? GROUP, NAME, UNION LOCAL, GROUP NO., NAME AND ADDRESS OF PROVIDER OF BENEFITS

☐ YES ☐ NO IF YES, GIVE

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?

24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO | YES — IF YES, ENTER BRIEF DESCRIPTION AND DATES

25. IS TREATMENT RESULT OF AUTO ACCIDENT? NO | YES

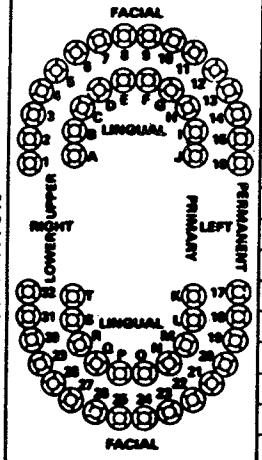
26. OTHER ACCIDENT? NO | YES

27. ARE ANY SERVICES COVERED BY ANOTHER PLAN? NO | YES

28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO | YES — (IF NO, REASON FOR REPLACEMENT) — 29. DATE OF PRIOR PLACEMENT

30. IS TREATMENT FOR ORTHODONTICS? NO | YES — IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED, MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH X



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.

LINE NO.	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	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.

▶ _____ DATE _____
SIGNED (DENTIST)

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

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.