ProBenefits Administrators
100 Corporate Pky, Suite 342
Amherst, NY 14226

Attending Dentist's Statement

Patient Section

Check one: ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services

1. Patient name first m.i. last	2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other _____	3. Sex M F	4. Patient birthdate MM DD YYYY	5. If full time student school city
6. Employee's name and mailing address	7. Employee Social Security Number	8. Employee birthdate MM DD YYYY	9. Employer (company) name and address	10. Group number

11. Is patient covered by another dental plan? ☐ Yes ☐ No If yes, indicate:	12-a. Name and address of carrier(s).	12-b. Group no.(s)	13. Name and address of employer

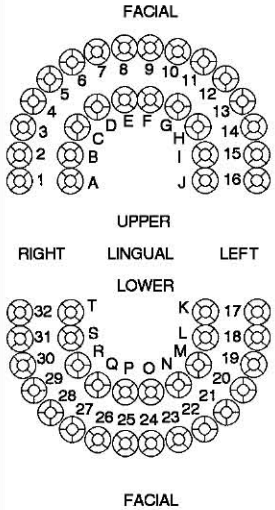
AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Provider, Insurer, or other Organization to release any information regarding any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.	Signed (Patient or parent if minor)	Date
AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named dentist of the dental benefits otherwise payable to me.	Signed (Employee)	Date
CERTIFICATION - I certify that the foregoing information is true and correct.	Signed (Patient or parent if minor)	Date

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Dentist Section

14. Dentist name	22. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates.
15. Mailing address	23. Is treatment a result of auto accident?			
	24. Other accident?			
City, State, Zip	25. Are any services covered by another plan?			
16. Dentist Soc. Sec. or T.I.N. 17. Dentist license no. 18. Dentist phone no.	26. If prosthesis, is this initial placement?			(If no, reason for replacement) 27. Date of prior placement
19. First visit date current series 20. Place of treatment Office Hosp ECF Other	21. Radiographs or models enclosed? No Yes How many?	28. Is treatment for orthodontics?		If services already commenced enter: Date appliances placed Mos. treatment remaining

Identify missing teeth with an "x"



30. Remarks for unusual services

29. Examination and treatment plan: List in order from tooth no. 1 through tooth no. 32 - Use the charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, material used, etc.) Line No.	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 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	

(DPP 6/04)