# DENTAL EXPENSE BENEFITS

eastern benefit systems, inc.
200 Freeway Dr., East, East Orange, NJ 07018

## PART 1 – EMPLOYEE

1. PATIENT NAME
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 LAST
7. EMPLOYEE SOCIAL SECURITY NO.
8. EMPLOYEE MAILING ADDRESS
CITY/STATE/ZIP
9. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? ☐ YES ☐ NO
10. IS TREATMENT RESULT OF AUTO ACCIDENT? ☐ YES ☐ NO
11. EMPLOYER'S NAME
12. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO
If YES, indicate: NAME SOC. SEC. NO.
13. NAME AND ADDRESS OF EMPLOYER IN ITEM 11
14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO *If YES, indicate:* DENTAL PLAN NAME UNION LOCAL GROUP NO. NAME AND ADDRESS OF CARRIER

15(A). *I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZED RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.*

*SIGNED (PATIENT, OR PARENT IF MINOR)* *DATE*

15(B). *I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE DENTAL PLAN BENEFITS OTHERWISE PAYABLE TO ME.*

*SIGNED (EMPLOYEE)* *DATE*

## PART 2 – DENTIST

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?

| | NO | YES | IF YES, ENTER BRIEF DESCRIPTION AND DATES |
|---|---|---|---|
| 24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | | | |
| 25. IS TREATMENT RESULT OF AUTO ACCIDENT? | | | |
| 26. OTHER ACCIDENT? | | | |
| 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, ENTER DATE APPLIANCES PLACED; MOS TREATMENT REMAINING |

32. ☐ PRE-DETERMINATION ESTIMATE

31. EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32 – USE CHARTING SYSTEM SHOWN

| TOOTH # OR LETTER | SURFACE | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) | DATE SERVICE PERFORMED MO. DAY YR. | PROCEDURE NUMBER (SEE REVERSE) | FEE | PRE-DETERMINED ESTIMATE |
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| | | | | TOTAL FEE | $ | $ |

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UPPER / LOWER — RIGHT — LINGUAL — PRIMARY — LEFT — PERMANENT

Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
Primary: A B C D E F G H I J K L M N O P Q R S T

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INDICATE MISSING TEETH WITH AN X

33. DENTIST SIGNATURE ____________ DATE ________

34. I HEREBY CERTIFY THAT SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE NAMED PATIENT ON THE DATES INDICATED AND THAT THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO THE MAJORITY OF MY PATIENTS.

SIGNED ____________ DATE ________

*Must be furnished under Authority of Law when Benefits Assigned.

EBS/5080