

# DENTCARE DELIVERY SYSTEMS, INC.

NOTE: ALL INFORMATION MUST BE PRINTED  
TREATMENT OVER \$250 MUST BE PREAUTHORIZED  
SEND COMPLETE FORMS TO: HEALTHPLEX  
60 CHARLES LINDBERGH BLVD, UNIONDALE, NY 11553

DENTIST'S PRE-TREATMENT ESTIMATE  
 DENTIST'S STATEMENT OF ACTUAL SERVICES

(516)-542-2200 (800) 468-0600

1. Patient Name		2. Relationship to Employee Self   Spouse   Child   Other		3. Sex M   F		4. Patient Birthdate Mo   Day   Year		5. Fulltime Student School		City	
8. Employee/Subscriber Name First Middle Last			7. Employee/Subscriber Social Security No.			9. Subscriber Date of Birth			Name of Group Dental Plan		
3. Employee/Subscriber Mailing Address						10. Employer (Company) Name and Address					
City, State, Zip											

11. Group No. GCDPP90648		12. Location (Local)		13. Are Other Family Members Employed? Employee Name Soc. Sec. No.		Date of Birth		14. Name and Address of Employer in Item 13.			
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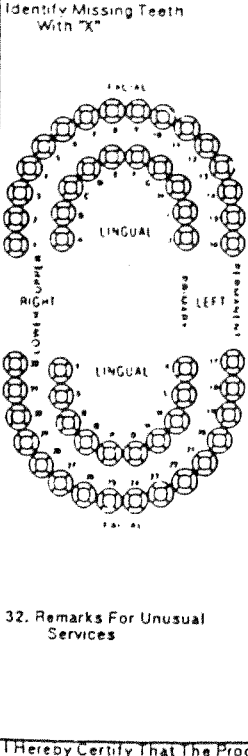
15. Is Patient Covered by Another Dental Plan?		Dental Plan Name		Union Local		Group No.		Name and Address of Carrier			
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I certify that I have read and understand the eligibility requirements for this program as described in the plan and that the patient for whom the claim is made is eligible for benefits. I further certify that neither I nor any of my dependents is covered by any other enrollment in a group dental insurance program. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signed \_\_\_\_\_ Date \_\_\_\_\_

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?		No		Yes					
City, State, Zip		26. Other Accident?		No		Yes					
18. Dentist (Soc. Sec. Or I.D.N.)		19. Dentist Lic. No.		20. Dentist Phone No.		27. Are Any Services Covered By Another Plan?		No		Yes	

21. Date of Current Series		22. Place of Payment Office   Hosp.   ECF   Other		23. Radiographs by Models Enclosed?		No		Yes		How Many?		26. Is Treatment for Orthodontics?		No		Yes		27. Services Already Commenced Enter.		Date Appliances Placed		28. Mos. Treatment Remaining?	
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31. Examination and Treatment Plan - List in Order From Tooth No. 1 Through Tooth No. 32. - Use Charting System Shown	Tooth # Or Let.	Surface	Description of Service (Including X-Rays, Prophylaxis, Materials 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						
	16						
	17						
	18						
	19						
	20						

I hereby certify that the procedures as indicated by date have been completed

SIGNED (DENTIST) \_\_\_\_\_ Date \_\_\_\_\_

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	