

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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		3. SEX M F <input type="checkbox"/> <input type="checkbox"/>		4. PATIENT BIRTHDATE MO. DAY YEAR		5. IF FULL-TIME STUDENT SCHOOL CITY	
6. EMPLOYEE NAME FIRST MIDDLE LAST				7. EMPLOYEE SOCIAL SECURITY NO.		9. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
8. EMPLOYEE MAILING ADDRESS				10. IS TREATMENT RESULT OF AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
CITY/STATE/ZIP				BROOKHAVEN SCIENCE ASSOCIATES					
11.		12. ARE OTHER FAMILY MEMBERS EMPLOYED? NAME <i>If YES, indicate:</i>		<input type="checkbox"/> YES <input type="checkbox"/> NO SOC. SEC. NO.		13. NAME AND ADDRESS OF EMPLOYER IN ITEM 12			
14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If YES, indicate:</i>		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.					15(B). I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE DENTAL PLAN BENEFITS OTHERWISE PAYABLE TO ME.				
SIGNED (PATIENT, OR PARENT IF MINOR) _____					SIGNED (EMPLOYEE) _____				
DATE _____					DATE _____				

PART 2 - DENTIST

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 T.I.N.*		19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		27. ARE ANY SERVICES COVERED BY ANOTHER PLAN? NO YES											
						(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT											
21. FIRST VISIT DATE CURRENT SERIES		22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?		30. IS TREATMENT FOR ORTHODONTICS NO YES											
						IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS TREATMENT REMAINING											
32. <input type="checkbox"/> 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			
<p style="text-align: center;">LABIAL</p> <p style="text-align: center;">LABIAL</p> <p style="text-align: center;">INDICATE MISSING TEETH WITH AN X</p>																	
		33. DENTIST SIGNATURE _____								TOTAL FEE \$ _____							
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.								<i>*Must be furnished under Authority of Law when Benefits Assigned.</i>									
SIGNED _____																	
DATE _____																	