

MAIN THIS CLAIM FORM PROMPTLY TO:

The Dental Shop
100 Corporate Pky, Suite 342
Amherst, NY 14226

New York City Transit

Attending Dentist's Statement

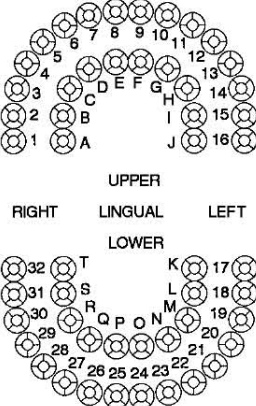
Patient Section

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

1. Patient name first m.i. last	2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> 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 NYCT Plan B	10. Group number 60070
11. Is patient covered by another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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?								
City, State, Zip	24. Other accident?								
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
29. Examination and treatment plan: List in order from tooth no. 1 through tooth no. 32 - Use the charting system shown.									
Identify missing teeth with an "x"		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	
FACIAL				1					
				2					
UPPER				3					
RIGHT LINGUAL LEFT				4					
LOWER				5					
32 T K 17				6					
31 S L 18				7					
30 R M 19				8					
29 Q N 20				9					
28 P O 21				10					
27 26 25 24 23 22				11					
FACIAL				12					
30. Remarks for unusual services				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	