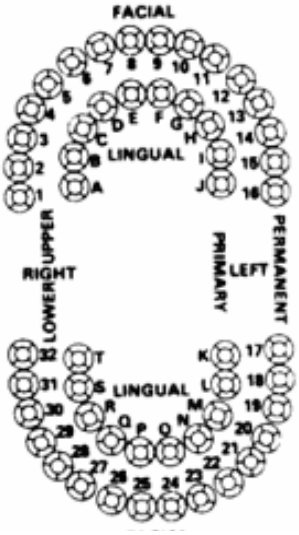
ATTENDING DENTIST'S STATEMENT

PREFERRED PGP GROUP PLANS, INC.

BYRAM HILLS TEACHERS ASSOCIATION BTF
% PREFERRED GROUP PLANS, INC.
PO Box 15136
Albany, NY 12212-5136
(518) 641-0321• (800) 573-7474 FAX: (518) 641-0325

CHECK ONE
__DENTIST'S PRE-TREATMENT ESTIMATE
__DENTIST'S STATEMENT OF ACTUAL SERVICES

1. EMPLOYEE NAME		SS #	2. ELIGIBILITY VERIFIED BY
3. ADDRESS	CITY	STATE OR PROVINCE	ZIP
4. PATIENT NAME (IF A DEPENDENT)	5. RELATIONSHIP TO EMPLOYEE	6. BIRTH DATE	7. STUDENT STATUS YES ___ NO ___
8. EMPLOYER NAME	GROUP NUMBER 6900	9. DOES PATIENT HAVE OTHER DENTAL COVERAGE? YES ___ NO ___ IF "YES" PLEASE IDENTIFY	
10. GROUP DENTAL PLAN NAME **BYRAM HILLS TEACHERS ASSOCIATION BTF**		11. PLAN NUMBER 6900	
13. DENTIST'S NAME (PRINT)	14. LICENSE NO	15. INDIVIDUAL PRACTITIONERS SS # _____ - _____ - _____ ALL OTHERS - EMPLOYER TIN _____ - _____ MUST BE FURNISHED UNDER AUTHORITY OF LAW	
16. ADDRESS CITY STATE OR PROVINCE ZIP			
17. IS ANY OF THE TREATMENT FOR (A) ORTHODONTIC PURPOSE? YES ___ NO ___	(B) ACCIDENTAL INJURY YES ___ NO ___	(C) OCCUPATIONAL INJURY? YES ___ NO ___	
18. IF PROSTHESIS. IS THIS INITIAL PLACEMENT? YES ___ NO ___ IF NO, REASON FOR REPLACEMENT	19. DATE OF PRIOR PLACEMENT	20. ARE X-RAYS ENCLOSED? YES ___ NO ___ IF YES HOW MANY?	



INDICATE MISSING TEETH WITH AND "X"

REMARKS FOR UNUSUAL SERVICES

X-Rays may be requested for certain services.

EXAMINATION AND TREATMENT RECORD - USE CHARTING SYSTEM SHOWN								FOR OFFICE USE ONLY
TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DOS MO	DY	YR	ADA PROCEDURE NUMBER	FEE	
For pre-treatment estimates, proposed treatment should be submitted exclusive of dates. Form will be returned reflecting Benefits Payable. When work is completed, form should be resubmitted reflecting dates of service. Predetermined benefits valid only if services performed while patient's insurance is in force.						TOTAL FEE CHARGED		
						DEDUCTIBLE		
						BALANCE		

I HAVE REVIEWED THE FOREGOING TREATMENT PLAN I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

SIGNED (PATIENT) DATE

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE ___ HAVE BEEN ___ PERFORMED

SIGNED (DENTIST) DATE

I hereby authorize payment directly to the above-named dentist of the benefits payable, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization, or incurred when my insurance is no longer in effect.

SIGNED (INSURED) DATE