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ATTENDING DENTIST'S STATEMENT

SIGN BELOW FOR PREDETERMINATION * OR PAYMENT **

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F		IMPORTANT 4. PATIENT BIRTHDATE MO. DAY YR.		5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL		CITY	
6. EMPLOYEE/SUBSCRIBER NAME LAST FIRST MIDDLE INITIAL		7. SUBSCRIBER I.D. NUMBER		IMPORTANT		OR 1		OR 2		OR 3	
8. EMPLOYEE HOME ADDRESS		9. EMPLOYER (COMPANY) NAME AND ADDRESS Abilities First Inc.		OR 4		OR 5		OR 6		OR 6	
CITY, STATE ZIP		ZIP CODE		10. GROUP NUMBER 11603		11. DELTA - COVERED EMPLOYEE BIRTHDATE MO. DAY YR.		12. SPOUSE NAME		13. SPOUSE BIRTHDATE MO. DAY YR.	
14. NAME AND ADDRESS OF CARRIER		15. SPOUSE I.D. NUMBER									

DENTIST NAME		IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES	
MAILING ADDRESS		IS TREATMENT RESULT OF AUTO ACCIDENT?					
CITY, STATE ZIP		OTHER ACCIDENT?					
DENTIST I.D. NUMBER (NPI)		DENTIST LICENSE		DENTIST PHONE NO.		IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	
FIRST VISIT DATE CURRENT SERIES		PLACE OF TREATMENT OFFICE OTHER		RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/>		HOW MANY? IS TREATMENT FOR ORTHODONTICS?	
						IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING	

IDENTIFY MISSING TEETH WITH "X" FACIAL	EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN.						
	TOOTH # OR LETTER	SURFACES MOJ DLF	Description Of Services Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO. DAY YR.	ADA PROCEDURE NUMBER	FEE	
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* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF BENEFITS DENTIST SIGNATURE _____ DATE _____		I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT. PATIENT SIGNATURE _____ DATE _____		TOTAL FEE CHARGED _____ PATIENT PAYS _____ DELTA PAYS _____ AMOUNT APPLIED TO DEDUCTIBLE _____	
** TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE. DENTIST SIGNATURE _____ DATE _____					

FORM DD/NY-0016-04-10