ATTENDING DENTIST'S STATEMENT

GREENBURGH TEACHERS FEDERATION
WELFARE FUND
C/O PREFERRED GROUP PLANS, INC.
P.O. Box 15136
Albany, NY 12212-5136

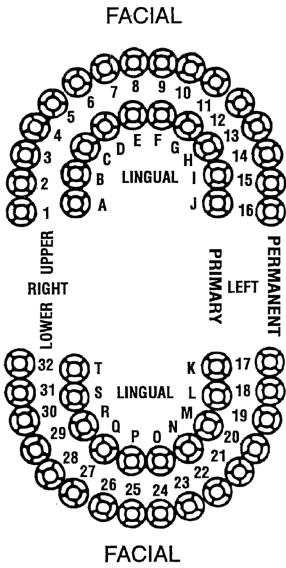
CHECK ONE

☐ 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)	RELATIONSHIP TO EMPLOYEE	6.BIRTHDATE	7. STUDENT STATUS YES ☐ NO ☐
8. EMPLOYER NAME **GREENBURGH TEACHERS FEDERATION W.F.**	GROUP NUMBER **8200**	9. DOES THE PATIENT HAVE OTHER DENTAL COVERAGE? YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY	
10. GROUP DENTAL PLAN NAME **GREENBURGH TEACHERS FEDERATION WELFARE FUND**		11. PLAN NUMBER **8200**	
12. DENTISTS NAME (PRINT)	13. LICENSE NO.	14. INDIVIDUAL PRACTITIONERS SS # _____-___-_______	
15. ADDRESS / CITY	STATE OR PROVINCE / ZIP	ALL OTHERS - EMPLOYER T.I.N. # ______-_____________	

16. IS ANY OF THE TREATMENT FOR: (A) ORTHODONTIC PURPOSE? YES ☐ NO☐ (B) ACCIDENTAL INJURY? YES ☐ NO ☐ (C) OCCUPATIONAL INJURY? YES ☐ NO ☐

17. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? YES ☐ NO☐ IF "NO", REASON FOR REPLACEMENT	18. DATE OF PRIOR PLACEMENT	ARE X-RAYS ENCLOSED? YES ☐ NO☐ IF "YES", HOW MANY?



EXAMINATION AND TREATMENT RECORD - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	MO	DOS DY	YR	ADA PROCEDURE NUMBER	FEE	FOR OFFICE USE ONLY
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		

INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES

X-Rays may be requested for certain services.

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

SIGNED (PATIENT) ______________________ DATE ____________

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

SIGNED (DENTIST) ______________________ DATE ____________

I hereby authorize payment 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 ____________