



PATIENT SECTION
Check One:
Dentist's pre-treatment estimate
Dentist's statement of actual services
Return Claim to:
The United States Life Insurance Company in the City of New York
P O Box 1581
Neptune, NJ 07754-1581
1. Patient name First M.I. Last
2. Relationship to Employee
3. Sex M F
4. Patient birthdate MO DAY YR
5. If full-time student School City
6. Employee/Subsriber name and mailing address
7. Employee/Subsriber soc. sec. number
8. Employee/Subsriber birthdate MM DD YYYY
9. Employer (Company) Name and Address
10. Group Number
11. Is Patient covered by another plan of benefits?
12-A. Name and address of carrier(s)
12-B. Group no.(s)
13. Name and Address of employer
14-A. Employee/Subsriber name (if different than patient's)
14-B. Employee/Subsriber Soc. sec. number
14-C. Employee/Subsriber birthdate MO DAY YR
15. Relationship to Patient

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.
I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.
Signed (Patient, or parent if minor) Date
Signed (Insured person) Date

DENTIST SECTION

16. Dentist Name
17. Mailing Address
18. Dentist Soc. Sec. or T.I.N.
19. Dentist License no.
20. Dentist Phone no.
21. First visit date current series.
22. Place of treatment Office, Hosp., ECF., Other
23. Radiographs or models enclosed?
24. Is treatment result of occupational illness or or injury?
25. Is treatment result of auto accident?
26. Other accident?
27. Are any services covered by another plan?
28. If prosthesis Is this initial placement?
29. Date of prior placement
30. Is treatment for orthodontics?
31. If services already commenced, enter.
Date appliances placed.
Mos. treatment remaining?

Table with 7 columns: Tooth # or letter, Surface, Description of service (Including x-rays, prophylaxis, materials used, etc.) Line No., Date service performed mo. day year, Procedure number, Fee, For administrative use only. Includes dental chart diagram and 32. Remarks for unusual services.

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