# ATTENDING DENTIST'S STATEMENT

**CHECK ONE:**

☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

***Any person who, knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which is a crime and subject to criminal prosecution.***

**SUBMIT COMPLETED FORM TO:**

Group Marketing Services, Inc.

**P.O. Box 19040, Kalamazoo, MI 49019-0040**

1 PATIENT NAME

2 RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER

3 SEX: M | F

4 PATIENT BIRTHDATE: MO | DAY | YEAR

5 IF FULL TIME STUDENT: SCHOOL | CITY

6 EMPLOYEE NAME: FIRST | MIDDLE | LAST

7 EMPLOYEE SOCIAL SECURITY NO.

10 NAME OF EMPLOYER

8 EMPLOYEE MAILING ADDRESS

11 GROUP ID NUMBER

9 CITY, STATE, ZIP

12 EMPLOYEE'S CERTIFICATE NUMBER

13 IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ NO ☐ YES

IF YES, ______________________
EMPLOYER'S NAME | EMPLOYEE NAME | NAME OF CARRIER

14 I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT OR PARENT IF MINOR) | DATE

15 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

16 DENTIST NAME

17 MAILING ADDRESS

CITY, STATE, ZIP

18 DENTIST (SOC SEC OR T.I.N.) | 19 DENTIST LIC. NO. | 20 DENTIST PHONE NO.

| | NO | YES | |
|---|---|---|---|
| 24 IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | | | IF YES, ENTER BRIEF DESCRIPTION AND DATES |
| 25 IS TREATMENT RESULT OF AUTO ACCIDENT? | | | |
| 26 OTHER ACCIDENT? | | | |
| 27 ARE ANY SERVICES COVERED BY ANOTHER PLAN? | | | |
| 28 IF PROTHESIS, IS THIS INITIAL PLACEMENT? | | | (IF NO, REASON FOR REPLACEMENT) — 29 DATE OF PRIOR PLACEMENT |
| 30 IS TREATMENT FOR ORTHODONTICS? | | | IF SERVICES ALREADY COMMENCED ENTER — DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING? |

21 FIRST VISIT DATE CURRENT SERIES

22 PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER

23 RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY?

IDENTIFY MISSING TEETH WITH AN "X"

FACIAL — UPPER — RIGHT — LINGUAL — PRIMARY — PERMANENT — LEFT — LOWER — LINGUAL — FACIAL

Permanent teeth: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 (upper); 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 (lower)

Primary teeth: A B C D E F G H I J (upper); K L M N O P Q R S T (lower)

IDENTIFY MISSING TEETH WITH AN "X"

32 REMARKS FOR UNUSUAL SERVICES

31 EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN

| TOOTH # OR LTR | 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 |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST) | DATE

| | |
|---|---|
| **TOTAL FEE CHARGED** | |
| MAX. ALLOWABLE | |
| DEDUCTIBLE | |
| CARRIERS | |
| CARRIER PAYS | |
| PATIENT PAYS | |

UNDERWRITTEN BY: Assurity Life Insurance Company

**ASSURITY LIFE INSURANCE COMPANY**

50462 G - M5 #1 REV 12/01

# HOW TO FILE YOUR DENTAL CLAIM

**A PRE-TREATMENT ESTIMATE MAY BE FILED IF YOU DESIRE.**

1. Employee must complete numbers 1 to 15 on Attending Dentist's Statement, sign and date form.

2. Dentist must put an "X" in the "Dentist's Pre-Treatment Estimate" box and complete numbers 16 to 32 indicating his/her usual charges.

3. Employee or Dentist submits completed form to Group Marketing Services, Inc.

4. After review, the Insurer will notify the Dentist of the Pre-Treatment Estimate benefits based on the proposed course of treatment.

5. When treatment is completed, the Dentist should complete "Date Service Performed" section on the estimate benefit copy received, sign and date and re-submit to Group Marketing Services, Inc. Benefits due on the completed treatment will then be considered.

The purpose of a Pre-Treatment Estimate is to avoid any misunderstanding between the Patient, Dentist, and Insurer on benefits available.

In order to expedite the Pre-Treatment Estimate and/or final payment, it is necessary that available X-rays be submitted when the course of treatment includes periodontal services, gold restorations, crowns or bridgework. X-rays may also be requested for other services. Failure to submit X-rays will delay processing of the Pre-Treatment Estimate and/or claim.

**—— X-RAYS WILL BE RETURNED TO THE DENTIST PROMPTLY ——**

Routine oral exams, scaling and cleaning, fluoride treatments, X-rays and emergency treatment may be performed prior to the submission of the Pre-Treatment Estimate.

**CLAIMS PROCEDURE**

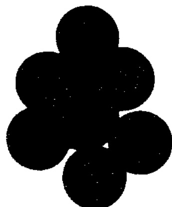
1. Employee must complete number 1 to 15, sign and date.

2. Dentist must complete numbers 16 to 32 after services are provided, sign and date.

3. Completed form is to be submitted to Group Marketing Services, Inc.

**—— PLEASE BE SURE TO COMPLETE ALL AREAS OF THE FORM.
INCOMPLETE INFORMATION WILL DELAY THE PROCESSING OF YOUR CLAIM. ——**

If you have questions about your claim, please contact:



GroupMarketing
Services, Inc.

**P.O. Box 19040
Kalamazoo, MI 49019-0040
(616) 343-2611
(269) 343-2611 After July, 2002.**