ATTENDING DENTIST'S STATEMENT

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

SUBMIT COMPLETED FORM TO:

GroupMarketing Services, Inc.
P.O. Box 19040, Kalamazoo, MI 49019-0040

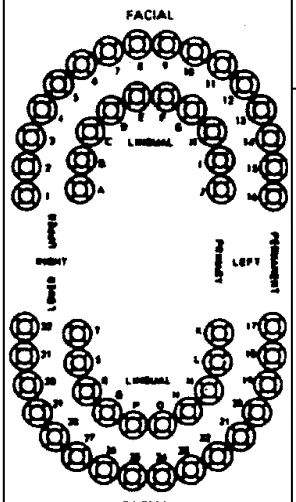
1. EMPLOYER NAME		2. GROUP/CASE NO.	CERT. NO.
3. PATIENT'S NAME	4. FULL TIME STUDENT? YES □ NO □ IF YES NAME AND ADDRESS OF SCHOOL	5. DATE OF BIRTH	6. RELATIONSHIP
7. INSURED'S NAME (First-Middle Initial-Last)	INSURED'S SOC. SEC. NO.	8. DATE OF BIRTH	9. THIS CLAIM FOR □ MY SELF □ MY SPOUSE □ MY CHILD
10. INSURED'S ADDRESS (Street No., City-State- Zip Code)			
11. SPOUSE'S NAME	12. SPOUSE'S DATE OF BIRTH	13. IS SPOUSE EMPLOYED? ☐ YES ☐ NO	14. IF YES, NAME AND ADDRESS OF EMPLOYER
15. ARE YOU OR YOUR DEPENDENTS PRESENTLY COVERED BY ANOTHER INSURANCE CARRIER PROVIDING DENTAL BENEFITS? □ YES □ NO		16. IF YES, NAME AND ADDRESS OF CARRIER, POLICY NO.	

17. AUTHORIZATION TO RELAEASE INFORMATION: I hereby authorize any Dentist, Physician, Hospital or other person who has attended me or examined me, to furnish Group Marketing Services, Inc. all dental, medical and other insurance information it may require. This information is to be used to determine my eligibility for insurance benefits. A photocopy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization upon request. This authorization shall remain valid for one year or the duration of the claim, whichever is less.

SIGNED (PATIENT OR PARENT, IF MINOR) DATE

18. DENTIST NAME	26. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIE F DESCRIPTION AND DATES
19. MAILING ADDRESS	27. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	28. OTHER ACCIDENT			
CITY, STATE, ZIP	29. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
20 DENTIST (SOC. SEC. OR T.I.N.) 21 DENTIST LIC. NO. 22 DENTIST PHONE NO.	30. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT? 31. DATE OF PRIOR PLACEMENT
23. FIRST VISIT DATE CURRENT SERIES 24. PLACE OF TREATMENT OFFICE, HOSP, ECF, OTHER 23. RADIOGRAPHS OR MODELS ENC.? NO YES HOW MANY?	32. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING?

IDENTIFY MISSING TEETH WITH "X"



INDICATE MISSING TEETH WITH AN "X"

34. REMARKS FOR UNUSUAL SERVICES

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

TOOTH # OR LET.	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO	DATE SERVICE PERFORMED MO. DA YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USES ONLY

TOTAL FEE CHARGED	
MAX ALLOWABLE	
DEDUCTIBLE	
CARRIERS	
CARRIER PAYS	
PATIENT PAYS	

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

SIGNED (DENTIST) DATE

MICHIGAN DENTAL PLAN 74-1170 REV. 3/95