Dental Network of America®

ATTENDING DENTIST'S STATEMENT

Instructions:
Staple X-rays (not required for amalgams, plastic and silicates) to top right corner.

Mail to: DENTAL NETWORK OF AMERICA
P.O. Box 5042
Oakbrook Terrace, IL 60181
1-800-323-6840 Indemnity Claims

Check one:
☐ DENTIST'S PRE-TREATMENT ESTIMATE PROVIDED PATIENT REMAINS COVERED
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

PATIENT SECTION

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/SUBSCRIBER NAME: FIRST | MIDDLE | LAST
7. SOCIAL SECURITY NUMBER
8. NAME OF GROUP DENTAL PROGRAM
9. EMPLOYEE/SUBSCRIBER MAILING ADDRESS: CITY | STATE | ZIP
10. EMPLOYER (COMPANY) NAME AND ADDRESS
11. GROUP NUMBER
12. LOCATION (LOCAL)
13. ARE OTHER FAMILY MEMBERS EMPLOYED: EMPLOYEE NAME | SOC. SEC. NO.
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN: DENTAL PLAN NAME | UNION LOCAL | GROUP NO. | POLICY NUMBER | NAME AND ADDRESS OF CARRIER

15a. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT OR PARENT IF MINOR) DATE

15b. I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT. I AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS.

SIGNED (EMPLOYEE) DATE

DENTIST SECTION

16. DENTIST NAME
17. MAILING ADDRESS: CITY | STATE | ZIP
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 | HOSPITAL | OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED: NO | YES | HOW MANY

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACC.?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, 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

IDENTIFY MISSING TEETH WITH "X"

FACIAL
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
A B C D E F G H I J
LINGUAL
UPPER RIGHT LOWER PRIMARY LEFT PERMANENT
K L M N O P Q R S T
LINGUAL
17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
FACIAL

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

		DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YEAR	PLAN USE	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

32. REMARKS FOR UNUSUAL SERVICES

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

TOTAL FEE CHARGED

SIGNED (DENTIST) DATE

Estimated benefits are subject to your coverage being in force at time service are performed and are subject to the specific limitations and exclusions listed in your plan booklet.

Any person who knowingly presents false, imcomplete or misleading information is guilty of a crime and may be subject to a fine or imprisonment or both. Please SEE REVERSE SIDE for more specific information.

DNP-ADS 2/98

WHITE - DNOA COPY / CANARY - DENTIST COPY