[ ] **DENTIST'S PRE-TREATMENT ESTIMATE**
[ ] **DENTIST'S STATEMENT OF ACTUAL SERVICES**

NOTE: ALL INFORMATION MUST BE PRINTED
TREATMENT OVER $250 MUST BE PREAUTHORIZED

Send Completed Forms to: Healthplex, Inc.
333 Earle Ovington Blvd.,Suite #300, Uniondale, NY 11553-3608
Providers Call - (888) 468-2183 **Press Option # 3 Members Call - (800) 468-0600** Press **Option # 1** **www.healthplex.com**
Email: info@healthplex.com

1. Patient Name	2. Relationship to Subscriber Self Spouse Child Other	3. Sex M F	4. Patient Birthate	5. Fulltime Student Y N School City
6. Subscriber Name First Middle Last		7. Subscriber Social Security Number		8. Subscriber Date of Birth
). Subscriber Mailing Address City, State, Zip				
0. Group No. GG-258	11. Are Other Family Members Employed? Y N Employee Name Soc. Sec. No.	12. Date of Birth	13. Name and Address of Employer in Item 11	
4. Is Patient Covered by Another Dental Plan? N	15. Dental Plan Name Policy it	Name and Address of Carrier		

6. I certify that I have read and understand the eligibility requirements for this program as described in the plan and that the patient for whom the claim is made is eligible for benefits. I urther certify that neither I nor any of my dependents is covered by any other enrollment in a group dental insurance program, except as noted. I have reviewed the following treatment lan. I authorize release of any information relating to this claim.

Signed (Patient or Guardian) Date

W To Be Completed By Dentist +

	17. Procedure Date (MM/DD/YY)	18. Area of Oral Cavity	119. Tooth #(s) / Letter(s)	20. Tooth Surface	21. Procedure Code	22. Description	23. Fee	24. Administrative
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5. Place an*W on each missing tooth																						26. Other fee(s)		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	1	J		
	32	31	30	29	28	27	26	24		23	22	21	20	19	18	17	T	S	R	Q	P	0	N	M	L	K		
8. **Remarks**																											27. Total Fee		

AUTHORIZATIONS

9.1 have been informed of the treatment plans and associated fees. I agree to be esponsible harges for dental services and materials not paid by my dental benefit plan, unless aw, or the treating dentist or dental practice has a contractual agreement with my plan ill or a portion of such charges. To the extent permitted by law, I consent to your use ind for all prohibited by prohibiting disclosure thi s c l a i m. I

X
Patient/Guardian signature Date

. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity, if allowed under my group guidelines. I understand hat benefits will automatically be assigned to my dentist if he or she is a Healthplex PPO Provider.

ubscriber signature Date

ANCILLARY CLAIM TREATMENT INFORMATION

31. Place of Treatment (Check applicable box)
❑ Provider's Office ❑ Hospital ❑ ECF ❑ Other

32. Number of Enclosures Radiographs(s) Oral Model(s) [ ]

33. Is Treatment for Orthodontics?
❑ No (Skip **34-35**) ❑ Yes (Complete **34-**

36. Replacement of Prosthesis? 37)

34 . Date Appliance Placed (MM/DD/YY) 35 . Months of Treatment

37. Date Prior Placement (MM/DD/YY)

38 . Treatment R esu l ting from (Check applicable box)
❑ Occupational Illness/injury ❑ Auto Accident ❑ Other accident

39. Date o6Accident (MM/DD/YY) 40. Auto Accident State

41. **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting

ame, Address, City,.State, Zip Code

42. Provider ID 43. License Number

44. SSN or TIN 45. Phone Number ( )

46. TREATING DENTIST AND TREATMENT LOCATION INFORMATION

I hereby certify that the procedure(s) as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submited are the actual fees I have charged and intend to collect for those procedures.

X
Signed (Treating Dentist) Date

47. Provider ID 48. License Number

49. Address, City, State, Zip Code

50. Phone Number ( ) 51. Treating Provider Specialty

IMPORTANT:

*Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."

PLEASE REVIEW BEFORE SUBMITTING CLAIMS

INSTRUCTIONS FOR MEMBERS:

1. Complete items 1 through 15 in full to assure positive and prompt payment. Please print or type.
2. The member must sign and date the claim.
3. If total charges for the planned course of treatment can reasonably be expected to be $250 or more, the form must be completed and submitted prior to the commencement of the course of treatment for a pre-determination of benefits. Healthplex will notify you of the benefits payable. X-RAYS MUST BE ATTACHED.
4. If total charges for the planned course of treatment will be less than $250, the claim form should be completed when treatment is completed.
5. Dental coverage is subject to specific limitations and exclusions. Please refer to your insurance booklet and certificate for a description of covered services, limitations, and exclusions.
6. THIS FORM WILL BE RETURNED IF IT IS INCOMPLETE OR INCORRECT.

INSTRUCTIONS FOR DENTIST:

Predetermination required for $250 or more, x-rays must be attached.

Generally, x-rays will not be required pre-operatively when the treatment plan involves only the use of Amalgam, Plastic, Silicate or Composite Restorations.

Diagnostic x-rays should be submitted for all other treatment. A pre-operative and post-operative x-ray is required where endodontic treatment has been rendered.

REMARKS FOR UNUSUAL SERVICES

Mail completed Form to:

Healthplex®

Leadership in Dental Plans

333 Earle Ovington Blvd., Suite 300 Uniondale, NY 11553-3608

Members Only Call Customer Service 1- 800-468-0600 Press Option 1
Providers Only Call Provider Hot Line 1- 888-468-2183 Press Option 3

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Email: Info@healthplex.com