

ATTENDING DENTIST'S STATEMENT TREATMENT PLAN AND CLAIM REPORT

SEAFARERS HEALTH AND BENEFITS PLAN

P.O. Box 380
Piney Point, Maryland 20674
(301) 994-9521

CHECK ONE: DENTIST'S PRE-TREATMENT ESTIMATE OF CHARGES
 DENTIST'S STATEMENT OF ACTUAL CHARGES

1. PATIENT NAME			2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER			3. SEX M F		4. PATIENT BIRTHDATE MON DAY YEAR			5. FULL TIME STUDENT SCHOOL		CITY						
6. EMPLOYEE NAME FIRST MIDDLE LAST			7. EMPLOYEE SOCIAL SECURITY NO.			9. NAME OF GROUP DENTAL PROGRAM													
8. EMPLOYEE / MAILING ADDRESS						10. EMPLOYEE (COMPANY) NAME AND ADDRESS													
CITY, STATE, ZIP																			
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.		NAME AND ADDRESS OF CARRIER											
15. A I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT. I AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME <input type="checkbox"/> Yes <input type="checkbox"/> No.						15. B I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.													
SIGNED (INSURED PERSON) _____						DATE _____			SIGNED (PATIENT OR PARENT IF MINOR) _____						DATE _____				
DENTIST'S INFORMATION																			
16. DENTIST NAME						24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY		NO		YES		IF YES. ENTER DESCRIPTION AND DATES							
17. MAILING ADDRESS						25. IS TREATMENT RESULT OF AN ACCIDENT													
CITY, STATE, ZIP						26. OTHER ACCIDENT													
						27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?													
18. DENTIST SOC. SEC. OR T.I.N.			19. DENTIST LICENSE NO.			20. DENTIST PHONE NO.			28. IF POSTHESIS IS THIS INITIAL PLACEMENT		(IF NO. REASON FOR REPLACEMENT)		DATE OF PRIOR PLACEMENT						
21. FIRST VISIT DATE CURRENT		22. PLACE OF TREATMENT OFFICE HOSP ECF OTHER		23. RADIOGRAPH OR MODELS ENCLOSED		NO		YES		HOW MANY?		30. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED ENTER		DATE APPLIANCES PLACED		MOS TREATMENT REMAINING	