PREFERRED PGP GROUP PLANS, INC.

ATTENDING DENTIST'S STATEMENT

ARLINGTON TEACHERS' ASSOCIATION
% PREFERRED GROUP PLANS, INC.
PO Box 15136
Albany, NY 12212-5136
(518) 641-0321• (800) 573-7474 FAX: (518) 641-0325

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

1. EMPLOYEE NAME	SS # (optional)	2. ELIGIBILITY VERIFIED BY

3. ADDRESS	CITY	STATE OR PROVINCE	ZIP

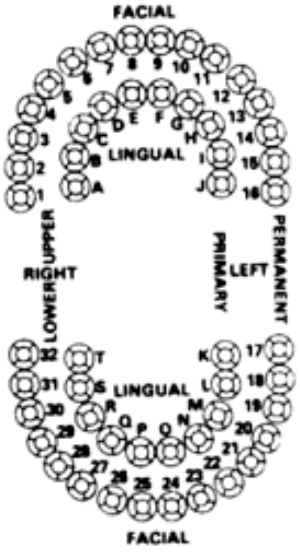
4. PATIENT NAME (IF A DEPENDENT)	5. RELATIONSHIP TO EMPLOYEE	6. BIRTH DATE	7. STUDENT STATUS YES __ NO __

8. EMPLOYER NAME	GROUP NUMBER	9. DOES PATIENT HAVE OTHER DENTAL COVERAGE? YES __ NO __ IF "YES" PLEASE IDENTIFY
Arlington Teachers' Association	4000	

10. DENTIST'S NAME (PRINT)	11. LICENSE NO	12. INDIVIDUAL PRACTITIONERS SS # _____ - _____ _____
13. ADDRESS CITY STATE OR PROVINCE ZIP		ALL OTHERS - EMPLOYER TIN _____ - _____ MUST BE FURNISHED UNDER AUTHORITY OF LAW

14. IS ANY OF THE TREATMENT FOR
(A) ORTHODONTIC PURPOSE? YES __ NO __ (B) ACCIDENTAL INJURY? YES __ NO __ (C) OCCUPATIONAL INJURY? YES __ NO __

15. IF PROSTHESIS. IS THIS INITIAL PLACEMENT? YES __ NO __ IF NO, REASON FOR REPLACEMENT	16. DATE OF PRIOR PLACEMENT	17. ARE X-RAYS ENCLOSED? YES __ NO __ IF YES HOW MANY?



INDICATE MISSING TEETH WITH AND "X"

REMARKS FOR UNUSUAL SERVICES

X-Rays may be requested for certain services.

EXAMINATION AND TREATMENT RECORD - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DOS MO	DY	YR	ADA PROCEDURE NUMBER	FEE	FOR OFFICE USE ONLY

For pre-treatment estimates, proposed treatment should be submitted exclusive of dates. Form will be returned reflecting Benefits Payable. When work is completed, form should be resubmitted reflecting dates of service.

Predetermined benefits valid only if services performed while patient's insurance is in force.

TOTAL FEE CHARGED		
DEDUCTIBLE		
BALANCE		

I HAVE REVIEWED THE FOREGOING TREATMENT PLAN I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

SIGNED (PATIENT)	DATE

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE _ HAVE BEEN _ PERFORMED

SIGNED (DENTIST)	DATE

I hereby authorize payment directly to the above-named dentist of the benefits payable, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization, or incurred when my insurance is no longer in effect.

SIGNED (INSURED)	DATE