ATTENDING DENTIST'S STATEMENT

PREFERRED GROUP PLANS, INC.

ARLINGTON TEACHERS' ASSOCIATION
c/o PREFERRED GROUP PLANS, INC.
PO Box 15136
Albany, NY 12212-5136
(518) 641-0321• (800) 573-7474 FAX: (518) 641-0325
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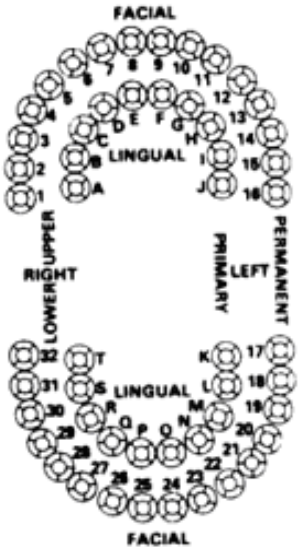
CHECK ONE
☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

1. EMPLOYEE NAME		SS #	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 4000	9. DOES PATIENT HAVE OTHER DENTAL COVERAGE? YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY		
10. GROUP DENTAL PLAN NAME **ARLINGTON TEACHERS' ASSOCIATION WELFARE TRUST**		11. PLAN NUMBER 4000		
13. DENTIST'S NAME (PRINT)	14. LICENSE NO	15. INDIVIDUAL PRACTITIONERS SS # _____ - _____ - _____ ALL OTHERS - EMPLOYER TIN _____ - _____ MUST BE FURNISHED UNDER AUTHORITY OF LAW		
16. ADDRESS CITY STATE OR PROVINCE ZIP				
17. IS ANY OF THE TREATMENT FOR (A) ORTHODONTIC PURPOSE? YES ☐ NO ☐		(B) ACCIDENTAL INJURY YES ☐ NO ☐	(C) OCCUPATIONAL INJURY? YES ☐ NO ☐	
18. IF PROSTHESIS. IS THIS INITIAL PLACEMENT? YES ☐ NO ☐ IF NO, REASON FOR REPLACEMENT	19. DATE OF PRIOR PLACEMENT	20. 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