The STANDARD INSURANCE

Reset

Attending Dentist's Statement
Treatment Plan and Insurance Claim Report

Standard Insurance Company, Group Dental Insurance
PO Box 82622 Lincoln NE 68501 800.547.9515 Tel 402.467.2030 Fax

Please check appropriate box: ☐ Dentist's pre-treatment estimate of charges ☐ Dentist's statement of actual charges

TO BE COMPLETED BY EMPLOYEE

1. Patient's Name	2. Social Security No.	3. If full time student, please provide name of school:
4. Sex ☐ Male ☐ Female	5. Patient's Birthdate	6. Relationship to Employee ☐ Self ☐ Spouse ☐ Child
7. Employee/Subscriber's name and mailing address: *(city, state, zip code)*		
8. Employer's (Company) name and mailing address: *(city, state, zip code)*		
9. Is patient covered by another Dental Plan? ☐ Yes ☐ No	If Yes, please provide the dental carrier's name and address: *(city, state, zip code)*	

If payment is to be made to provider, please sign below.

AUTHORIZATION TO PAY BENEFITS TO PROVIDERS

I hereby authorize payment of benefits to any providers of service, otherwise payable to me for services but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

Signature of Insured Person

Date

Patient or Parent please sign below.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I authorize The Standard to release information about me to any person/entity performing services in connection with the administration of the dental plan. I hereby certify the information provided is correct and true to the best of my knowledge.

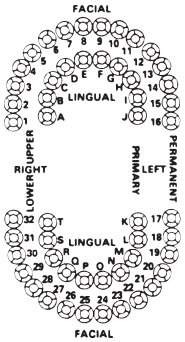
I understand this authorization shall remain inforce for 24 months. I understand that I have the right to revoke the authorization at any time by sending a statement to The Standard, and that a revocation of the authorization, or failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim. Revocation of the authorization may be a basis for denying my claim for benefits.

Signature of Patient *(or parent if patient is a minor)* Date

TO BE COMPLETED BY DENTIST

Dentist Name:		Dentist Social Security No. or TIN:	Dentist License No.:
Mailing Address:	City:	State: Zip:	Dentist Phone No.:
First Visit Date *(current series)*:	Office:	Place of Treatment: ☐ Hosp. ☐ ECF ☐ Other	Radiographs or Models Enclosed? ☐ Yes ☐ No How Many? _____
Is treatment result of occupational illness or injury? ☐ Yes ☐ No		If yes, enter brief description and dates.	
Is treatment result of auto accident? ☐ Yes ☐ No Other accident? ☐ Yes ☐ No			
Are any services covered by another plan? ☐ Yes ☐ No			
If crown or prothesis, is this initial placement? ☐ Yes ☐ No		If no, reason for replacement.	Date of Prior Placement:
Is treatment for orthodontics? ☐ Yes ☐ No		If service already commenced, please enter the date appliance was placed, and the number of months of treatment remaining. Date: _____ No. Mos.: _____	

Identify Missing Teeth with "X"



Remarks for Unusual Services

Examination and Treatment Plan – List in order from tooth no. 1 through tooth no. 32 – Use charting system shown.

Tooth # or Letter	Surface	Description of Service *(including x-rays, prophylaxis, materials used, etc.)* Line No.	Date Service Performed Mo Day Yr	Procedure Number	Fee	For Administrative Use Only

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

I hereby certify that the procedures as indicated by date have been completed.

► _____ _____
Signature of Dentist Date

TOTAL FEE CHARGED:	
Max. Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	