J.J. STANIS AND COMPANY, INC.
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Jericho, NY 11753

For additional dental claim forms, please visit us at our website:

www.jjstanisco.com

DENTAL CLAIM FORM

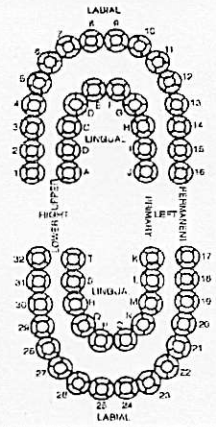
1. CHECK ONE (✓) ⌟ DENTIST FEE TREATMENT ESTIMATE ⌟ DENTIST STATEMENT OF ACTUAL SERVICES	2. PRIOR AUTHORIZATION NO. PATIENT ID NO.			3. CARRIER NAME AND ADDRESS	
PATIENT AND EMPLOYEE INFORMATION 4. PATIENT NAME	5. RELATIONSHIP TO EMPLOYEE ⌟ SELF ⌟ DAUGHTER ⌟ SPOUSE ⌟ SON ⌟ OTHER	6. SEX ⌟ M ⌟ F		7. PATIENT BIRTH DATE MONTH DAY YEAR	8. IF FULL TIME STUDENT SCHOOL CITY
9. EMPLOYEE/SUBSCRIBER NAME AND ADDRESS	10. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER	11. EMPLOYEE/SUBSCRIBER BIRTH DATE MONTH DAY YEAR		12. GROUP NUMBER	13. EMPLOYER NAME AND ADDRESS
14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ⌟ YES ⌟ NO - **IF YES, COMPLETE 15-18** IS PATIENT COVERED BY A MEDICAL PLAN? ⌟ YES ⌟ NO	15-A. NAME AND ADDRESS OF OTHER CARRIER(S)			15-B. GROUP NUMBER(S)	16. OTHER PLAN-EMPLOYER NAME/ADDRESS
17-A. OTHER PLAN - SUBSCRIBER NAME (IF DIFFERENT FROM PATIENT(S))	17-B. OTHER PLAN-SUBSCRIBER IDENTIFICATION NUMBER			17-C. SUBSCRIBER BIRTH DATE MONTH DAY YEAR	18. RELATIONSHIP TO PATIENT ⌟ SELF ⌟ DAUGHTER ⌟ SPOUSE ⌟ SON ⌟ OTHER

19. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN AND FEES. I AGREE TO BE RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I AUTHORIZE RELEASE OF ANY INFORMATION RELATED TO THIS CLAIM. PATIENT SIGNATURE DATE	20. I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTIST ENTITY. SIGNATURE (EMPLOYEE/SUBSCRIBER) DATE

BILLING DENTIST COMPLETES

21. NAME OF BILLING DENTIST OR DENTAL ENTITY							30. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER DESCRIPTION AND DATE					
22. ADDRESS WHERE PAYMENT SHOULD BE REMITTED							31. IS TREATMENT RESULT OF AUTO ACCIDENT?								
23. CITY, STATE, ZIP							32. OTHER ACCIDENT?								
24. DENTIST SSN OR TIN		25. DENTIST LICENSE NO.		26. PHONE NUMBER			33. IF PROSTHESIS, IS IT INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT		34. DATE OF PRIOR PLACEMENT			
27. 1ST VISIT	28. PLACE OF TX OFF ⌟ HOSPITAL ⌟ ECF ⌟ OTHER ⌟	29. RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY?		35. IS TREATMENT FOR ORTHODONTICS?			DATE APPLIANCES PLACED?		MISC. TREATMENT REMAINING?			

36. IDENTIFY MISSING TEETH WITH "X"



37. EXAMINATION AND TREATMENT PLAN

TOOTH	SURF	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, ETC.)	DATE OF SERVICE MO	DAY	YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

38. REMARKS FOR UNUSUAL SERVICES

39. I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES. SIGNED (TREATING DENTIST) LICENSE NUMBER DATE	41. TOTAL FEE CHARGED	
	42. PAYMENT BY OTHER PLAN	
	MAX ALLOWABLE	
40. ADDRESS WHERE TREATMENT WAS PERFORMED CITY STATE ZIP CODE	DEDUCTIBLE	
	CARRIER %	
	PATIENT PAYS	

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