PREFERRED PGP GROUP PLANS, INC.

ATTENDING DENTIST'S STATEMENT

P.O.Box 15136 Albany, NY 12212-5136
Phone (518) 641-0321
Fax (518) 641-0325
Toll Free 1-800-573-7474

NUMBER

CHECK ONE
☐ DENTIST'S PRETREATMENT 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 MO DAY YR | 7 STUDENT STATUS YES NO

8 EMPLOYER NAME | 9 DOES PATIENT HAVE OTHER DENTAL COVERAGE? YES NO IF "YES" PLEASE IDENTIFY

10 GROUP DENTAL PLAN NAME MINISINK VALLEY BT | 11 PLAN NUMBER D3900

13 DENTIST'S NAME (PRINT) | 14 LICENSE NO | 15 INDIVIDUAL PRACTITIONERS - SS# ALL OTHERS - EMPLOYER I. D. #

16 ADDRESS | CITY | STATE OR PROVINCE | ZIP

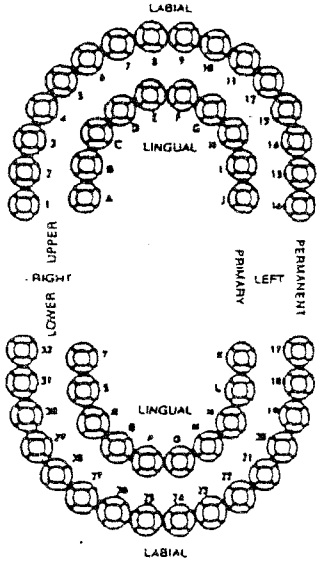
MUST BE FURNISHED UNDER AUTHORITY OF LAW

17. IS ANY OF THE TREATMENT FOR:
(A) ORTHODONTIC PURPOSES? 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 MO DA YR

20. ARE X-RAYS ENCLOSED? YES ☐ NO ☐
IF YES HOW MANY?



INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT RECORD - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YR	ADA PROCEDURE NUMBER	FEE	FOR CARRIER 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 ACTUALLY CHARGED		
DEDUCTIBLE		
BALANCE		
CARRIER PAYS		
CARRIER PAYS		

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

SIGNED (PATIENT OR PARENT IF MINOR) 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 PERSON) DATE

X-Rays may be requested for certain services.