Group Dental Non-Direct Claim Form

RETURN THIS FORM TO: M. A. DONNELLY & COMPANY

P. O. BOX 525
ANDES, NEW YORK 13731

ATTENDING DENTIST'S STATEMENT - DO NOT USE STAPLES

PART I - TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE — Self ☐ Spouse ☐ Child ☐ Other ☐
3. SEX — M ☐ F ☐
4. PATIENT BIRTH DATE — Mo. Day Year
5. IF FULL TIME STUDENT — School City
6. EMPLOYEE NAME *(First, Middle, Last)*
7. EMPLOYEE SOCIAL SECURITY NO.
8. EMPLOYEE MAILING ADDRESS
CITY, STATE, ZIP
9.
10. COMPANY (EMPLOYER) NAME AND ADDRESS:
HYDE PARK TEACHERS ASSOC.
BENEFIT TRUST
#5464
11. GROUP NUMBER: 55790
12. LOCATION
13. IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED? ☐ Yes ☐ No *If yes, Member's Name Social Security No.*
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13
SPOUSE BIRTH DATE — Mo. Day Year
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ Yes ☐ No — IF YES, DENTAL PLAN NAME — GROUP NO. — NAME AND ADDRESS OF CARRIER

AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature. — SIGNED (PATIENT OR PARENT IF MINOR) — DATE

AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me. — SIGNED (EMPLOYEE) — DATE

CERTIFICATION - I certify that the foregoing information is true and correct. — SIGNED (EMPLOYEE) — DATE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME

PART II - TO BE COMPLETED BY ATTENDING DENTIST

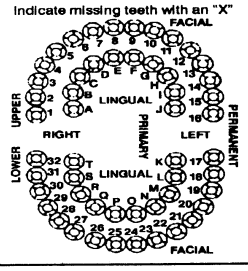
16. DENTIST NAME
17. MAILING ADDRESS
CITY, STATE, ZIP
18. TAX I.D. # TO BE USED FOR TAX REPORTING. — TAX I.D. # — SOC. SEC. #
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT — Office ☐ Hosp. ☐ ECF ☐ Other ☐
23. RADIOGRAPHS OR MODELS ENCLOSED? ☐ Yes ☐ No — HOW MANY?
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? — NO ☐ YES ☐ — IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT? — NO ☐ YES ☐
26. OTHER ACCIDENT? — NO ☐ YES ☐
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN? — NO ☐ YES ☐ — IF YES, NAME OF OTHER PLAN:
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? — NO ☐ YES ☐ — (IF NO, REASON FOR REPLACEMENT) — 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS? — NO ☐ YES ☐ — IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

CHECK ONE:
☐ PREDETERMINATION OF BENEFITS
☐ Statement of Actual Services

31. EXAMINATION AND TREATMENT PLAN-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32-USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE (i.e., M, O, D, B, L, LA, I)	DESCRIPTION OF SERVICE *(Including X-Rays, Prophylaxis, Materials Used, Etc.)*	DATE SERVICE COMPLETED Mo. Day Year	PROCEDURE NUMBER *(See Reverse)*	FEE

Indicate missing teeth with an "X"



32. Remarks for unusual services

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE. — SIGNED (DENTIST) — DATE — TOTAL FEE CHARGED

PART III

Part III - To Be Completed by Employer

1. EFFECTIVE DATE EMPLOYEE — DEPENDENT (if different)
2. HAS COVERAGE ON THIS EMPLOYEE EVER BEEN TERMINATED? ☐ Yes ☐ No — IF YES, DATE
3. WAS COVERAGE REINSTATED ☐ Yes ☐ No — IF YES, DATE
4. ELIGIBILITY VERIFIED ON — BY