ATTENDING DENTIST'S STATEMENT

AFSCME CARE Plan

To: OHIO AFSCME CARE PLAN
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420

CHECK FOR:
- ☐ DENTIST'S PRE-TREATMENT ESTIMATE
- ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES
- ☐ ADDRESS CHANGE

TO BE COMPLETED BY PATIENT

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE — SELF SPOUSE CHILD OTHER
3. SEX — M F
4. PATIENT BIRTHDATE — MO DAY YEAR
5. PATIENT SOCIAL SECURITY #
6. EMPLOYEE NAME — FIRST MIDDLE LAST
7. EMPLOYEE SUBSCRIBER SOCIAL SECURITY NO.
8. NAME OF GROUP DENTAL PROGRAM DENTAL BENEFIT
9. EMPLOYEE MAILING ADDRESS
10. EMPLOYER (COMPANY) NAME AND ADDRESS
CITY, STATE, ZIP — TELEPHONE
11. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME — SOC. SEC. NO. — EMPLOYEE DATE OF BIRTH
12. NAME AND ADDRESS OF EMPLOYER IN LINE 11
13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? — DENTAL PLAN NAME — UNION LOCAL — GROUP NO. — NAME AND ADDRESS OF CARRIER

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

_____ DATE _____
SIGNED (PATIENT OR PARENT IF MINOR)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE DENTAL PLAN BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN. I UNDERSTAND, THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION

_____ DATE _____
SIGNED (INSURED PERSON)

TO BE COMPLETED BY DENTIST

14. DENTIST NAME
15. MAILING ADDRESS
CITY, STATE, ZIP
16. DENTIST SOC. SEC. OR E.I.N
17. DENTIST LICENSE NO.
18. DENTIST PHONE NO.

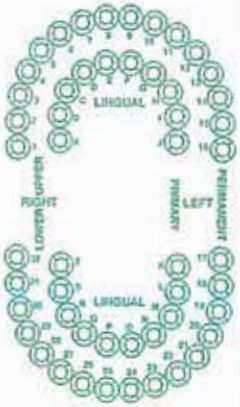
	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
19. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
20. IS TREATMENT RESULT OF AUTO ACCIDENT?			
21. OTHER ACCIDENT?			
22. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
23. IF PROSTHES IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACMENT) — 24. DATE OF PRIOR REPLACEMENT

ALL BENEFIT CLAIMS MUST BE SUBMITTED BY DECEMBER 31 AFTER THE END OF THE CALENDAR YEAR IN WHICH THE EXPENSE FOR THE DENTAL BENEFIT WAS PAID. FOR EXAMPLE, ALL BENEFIT CLAIMS FOR 2003 MUST BE SUBMITTED TO THE PROPER PLAN OFFICE BY DECEMBER 31, 2004.

IN ALL CASES OVER $400.00, EXCEPT IN EMERGENCIES WHERE NECESSARY PRE-DETERMINATION OF BENEFITS IS NOT OBTAINED, THE MAXIMUM FEE PAID BY THE DENTAL BENEFIT PROGRAM MAY BE LIMITED TO 80% OF THE AMOUNTS SHOWN IN THE SCHEDULE OF DENTAL BENEFITS.

IDENTIFY MISSING TEETH WITH "X"

FACIAL



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25. REMARKS FOR UNUSUAL SERVICES

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

Tooth # or letter	SURFACE	LINE NO.	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.)	DATE SERVICE PERFORMED MO DAY YEAR	ADA PROCEDURE NUMBER	FEE*	PLAN USE ONLY
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					
		16					
		18					
		19					
		20					

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE OF SERVICE HAVE BEEN COMPLETED

_____
SIGNED (DENTIST) — DATE

TOTAL FEE CHARGED
PLAN PAYS
PATIENT PAYS

FORM RETURNED TO DENTIST

DATE _____ REASON _____

BENEFIT APPROVAL BLOCK

DATE _____

BY _____ TITLE _____