RETURN TO:
TEACHERS HEALTH TRUST
P.O. Box 96238 Las Vegas, Nevada 89193-6238 (702) 794-0272

ATTENDING DENTIST'S STATEMENT

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE SELF | SPOUSE | CHILD | OTHER
3. SEX M | F
4. PATIENT BIRTHDATE MO | DAY | YEAR
5. IF FULL TIME STUDENT SCHOOL CITY

6. EMPLOYEE NAME FIRST MIDDLE LAST
7. EMPLOYEE SOCIAL SECURITY NO
9. NAME OF GROUP DENTAL PROGRAM **TEACHERS HEALTH TRUST**

8. EMPLOYEE MAILING ADDRESS
EMPLOYEE'S BIRTH MO DAY YEAR / /
10. EMPLOYER (COMPANY) NAME AND ADDRESS

11. GROUP NUMBER **20660**
12. ARE OTHER FAMILY MEMBERS EMPLOYED? YES ☐ NO ☐ EMPLOYEE NAME SOC SEC NO
13. NAME AND ADDRESS OF EMPLOYER IN ITEM 12

14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES ☐ NO ☐ DENTAL PLAN NAME UNION LOCAL GROUP NO. NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.
SIGNED (PATIENT, OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME
SIGNED INSURED PERSON DATE

DENTIST'S INFORMATION

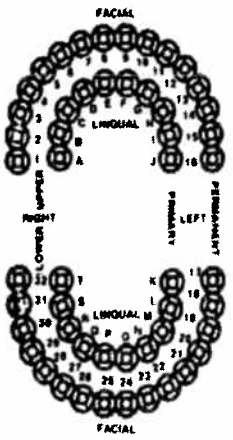
PLEASE PRESS FIRMLY

15. DENTIST NAME
16. MAILING ADDRESS
CITY STATE ZIP
17. DENTIST SOC. SEC. OR T.I. NO.
18. DENTIST LICENSE NO.
19. DENTIST PHONE NO.
20. FIRST VISIT DATE CURRENT SERIES
21. PLACE OF TREATMENT OFFICE | HOSP | ECF | OTHER
22. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
23. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
24. IS TREATMENT RESULT OF AUTO ACCIDENT?			
25. OTHER ACCIDENT?			
26. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT / 29. DATE OF PRIOR PLACEMENT
29. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

CHECK ONE: ☐ **DENTIST'S PRE-TREATMENT ESTIMATE** ☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

IDENTIFY MISSING TEETH WITH AN "X"



30. 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.	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE	ADMINISTRATIVE USE 100%	80%	50%

31. REMARKS FOR USUAL SERVICES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED
SIGNED (DENTIST) DATE

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	