ATTENDING DENTIST'S STATEMENT

PREFERRED GROUP PLANS, INC.
PO Box 15136
Albany, NY 12212-5136
(518) 641-0321•FAX: (518) 641-0325•(800) 573-7474

CHECK ONE
☐ DENTIST'S PRE-TREATMENT 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	7. STUDENT STATUS YES ☐ NO ☐

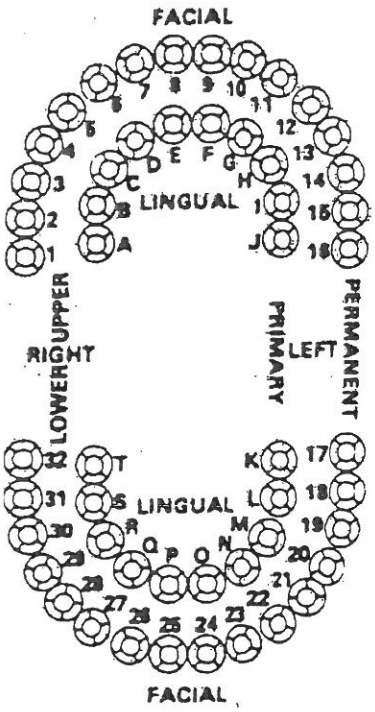
8. EMPLOYER NAME	GROUP NUMBER	9. DOES PATIENT HAVE OTHER DENTAL COVERAGE? YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY
Glens Falls City School District	2903	

10. GROUP DENTAL PLAN NAME	11. PLAN NUMBER
Glens Falls City School District	2903

13. DENTIST'S NAME (PRINT)	14. LICENSE NO	15. INDIVIDUAL PRACTITIONERS SS # ___-___-___ ALL OTHERS - EMPLOYER TIN ___-___ MUST BE FURNISHED UNDER AUTHORITY OF LAW
16. ADDRESS CITY STATE OR PROVINCE ZIP		

17. IS ANY OF THE TREATMENT FOR (A) ORTHODONTIC PURPOSE? 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	20. ARE X-RAYS ENCLOSED? YES ☐ NO ☐ IF YES HOW MANY?



INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES

X-Rays may be requested for certain services.

EXAMINATION AND TREATMENT RECORD - USE CHARTING SYSTEM SHOWN								FOR OFFICE USE ONLY
TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DOS MO	DOS DY	DOS YR	ADA PROCEDURE NUMBER	FEE	

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 CHARGED		
DEDUCTIBLE		
BALANCE		

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

SIGNED (PATIENT) 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.