

For additional dental claim forms,
please visit our website:
www.jjstanisco.com

Mail completed forms to:
J.J. STANIS AND COMPANY, I NC.
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Phone 516•465•3900 Fax 516•465•3920

Dental Expense Claim

To Be Completed by Employee (You must review the important statements on page 2 and sign where indicated before completing this section of the form.)

1. Patient First Name Middle Last		2. Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Patient Date of Birth Mo. / Day / Year	6. For Office Use
7. If Full-Time Student (Age 19 or Over) School City State			8. EMPLOYEE Social Security / ID Number	9. If Disabled (Age 19 or Over) <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Name of Group Dental Program WHEA-0687	
11. Employee First Name Middle Last			12. Employee Date of Birth	13. Office Phone (Area Code)			
14. Employee Residence Mailing Address			15. City, State, Zip				
16. Are other Family Members Employed? Name Social Security / ID Number		<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Date of Birth	18. Name and Address of Employer for Item 16			
19. Is Patient Covered by Another Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete the following): Dental Plan Name Group No. Name and Address of Carrier							
20. I Authorize Release of any Information Relating to this Claim. (Signature of Patient or Signature of Authorized Representative if Minor) _____ Date _____ If Authorized Representative, Relationship to Minor _____		21. I Certify that the Above Information is Correct. Employee Signature _____ Date _____		22. I Authorize Payment Directly to the Below-Named Dentist. Employee Signature _____ Date _____			

To Be Completed by Dentist

23. Dentist Name		24. Mailing Address City State Zip		
25. Dentist Phone Number	26. Dentist License Number	27. Dentist SSN or T.I.N.	28. Provider Specialty Code	29. NPI (Treating Dentist)
30. NPI (Billing Entity, if different)	31. First Visit Date Current Series	32. Place of Treatment <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other _____		33. Radiographs or Models Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No How Many? _____
34. Is Treatment Result of Occupational Illness or Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates)		35. Is Treatment Result of Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates)		
36. Other Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates)		37. Are any Services Covered by Another Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates)		
38. If Prosthesis, is this Initial Placement? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, Reason for Replacement)				39. Date of Prior Replacement
40. Is Treatment for Orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Services Already Commenced, Enter Date Appliance Placed			Months of Treatment Remaining

Dentist's – Pretreatment Estimate Statement of Actual Services (Be sure to sign below)*

	41. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)						
	Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo./ Day / Year	ADA Procedure Number	Fee	For Carrier Use Only

42. I Hereby Certify That The Services Listed Above <input type="checkbox"/> Will Be <input type="checkbox"/> Have Been Performed.		Total Fee	
*Signature of Dentist _____	Date Signed _____	Actually Charged	
43. Address where treatment was performed			
Street _____	City _____	State _____	Zip _____