ATTENDING DENTIST'S STATEMENT

SIEBA LTD
SPECIALISTS IN EMPLOYEE BENEFIT ADMINISTRATION
SM

Please send completed form to:

SIEBA, LTD.
111 Grant Ave, Ste 202
PO Box 5000
Endicott, NY 13761-5000

DENTIST SHOULD CHECK ONE

- ☐ PRE-TREATMENT ESTIMATE
- ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

EMPLOYEE SHOULD COMPLETE

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE (SELF / SPOUSE / CHILD / OTHER)	3. SEX (MALE / FEMALE)	4. PATIENT BIRTHDATE (MONTH / DAY / YEAR)

6. EMPLOYEE/SUBSCRIBER NAME (FIRST MIDDLE LAST)	7. EMPLOYEE/SUBSCRIBER IDENTIFER (SSN or ID#).	9. NAME OF GROUP DENTAL PROGRAM
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS		10. EMPLOYER (COMPANY) NAME AND ADDRESS
CITY,STATE,ZIP		

COMPLETE 13-15 IF COVERED BY ANOTHER DENTAL PLAN	13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME	IDENTIFIER (SSN or ID#).	14. NAME AND ADDRESS OF EMPLOYER ITEM 13
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME	UNION LOCAL / GROUP NO.	NAME AND ADDRESS OF CARRIER

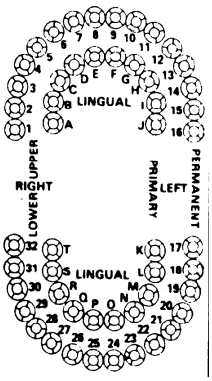
I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.	I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST.
X SIGNED (PATIENT OR PARENT IF MINOR) DATE	XX SIGNED (EMPLOYEE) DATE

DENTIST SHOULD COMPLETE

16. DENTIST NAME	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
17. MAILING ADDRESS	25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	26. OTHER ACCIDENT?			
CITY, STATE, ZIP	27. ARE ANY SERVICES COVERD BY ANOTHER PLAN?			
18. DENTIST SOC. SEC. OR T.I.N. 19. DENTIST LICENSE NO. 20. DENTIST PHONE NO.	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
21. FIRST VISIT DATE CURRENT SERIES / 22. PLACE OF TREATMENT (OFFICE / HOSP / ECF / OTHER) / 23. RADIOGRAPHS OR MODELS ENCLOSED? (NO / YES / HOW MANY?)	29. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED MOS TREATMENT REMAINING

Identify Missing Teeth with 'X'

FACIAL



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32. REMARKS FOR UNUSUAL SERVICES

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

TOOTH # OR LETTE	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS,MATERIASL, USED, ETC.) LINE NO.	DATE OF SERVICE PERFORMED	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				
		16				

SIGNATURE OF DENTIST OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS). I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT I PERSONALLY RENDERED THE ABOVE SERVICES AND THAT ALL CHARGES SHOWN REPRESENT MY USUAL CHARGE.

X
SIGNED (DENTIST) DATE

TOTAL FEE CHARGED

DOCTOR: We encourage your seeking a pre-treatment estimate on work expected to cost $150 or more. If you have any questions about pre-treatment or any other aspect of this Dental Assistance Plan, please feel free to call SIEBA, LTD. at (607) 786-3003 or (800) 252-4624.