


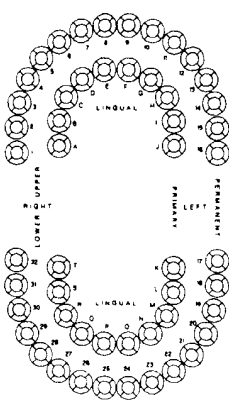
ATTENDING DENTIST'S STATEMENT

	To: OHIO AFSCME CARE PLAN 1603 East 27th Street Cleveland, Ohio 44114-4217 Phone (216) 781-6420	CHECK FOR: <input type="checkbox"/> DENTIST'S PRE-TREATMENT ESTIMATE <input type="checkbox"/> DENTIST'S STATEMENT OF ACTUAL SERVICES <input type="checkbox"/> ADDRESS CHANGE		
<b>TO BE COMPLETED BY PATIENT</b>				
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.		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		
_____ SIGNED (PATIENT OR PARENT IF MINOR)		_____ SIGNED (INSURED PERSON)		
DATE _____		DATE _____		

<b>TO BE COMPLETED BY DENTIST</b>				
14. DENTIST NAME	19. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
15. MAILING ADDRESS	20. IS TREATMENT RESULT OF AUTO ACCIDENT?			
CITY, STATE, ZIP	21. OTHER ACCIDENT?			
16. DENTISTS SOC. SEC. OR E.I.N.	17. DENTIST LICENSE NO.	18. DENTIST PHONE NO.	22. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	
			23. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	(IF NO, REASON FOR REPLACEMENT)
				24. DATE OF PRIOR REPLACEMENT

ALL BENEFITS 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 1995 MUST BE SUBMITTED TO THE PROPER PLAN OFFICE BY DECEMBER 31, 1996

**IN ALL CASES OVER \$250. EXCEPT IN EMERGENCIES, WHERE NECESSARY PRE-DETERMINATION OF BENEFITS IS NOT OBTAINED, THE MAXIMUM FEE PAID BY THE DENTAL BENEFIT PROGRAM WILL BE LIMITED TO 80% OF THE AMOUNTS SHOWN IN THE SCHEDULE OF DENTAL BENEFITS.**

IDENTIFY MISSING TEETH WITH "X" FACIAL  FACIAL 26. REMARKS FOR UNUSUAL SERVICES	25. EXAMINATION AND TREATMENT PLAN—LIST IN ORDER FROM TOOTH NO 1 THROUGH TOOTH NO. 32—USE CHARTING SYSTEM SHOWN						PLAN USE ONLY	
	Tooth # or Letter	SURFACE	LINE NO.	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YEAR	ADA PROCEDURE NUMBER		FEE*
			1					
			2					
			3					
			4					
			5					
			6					
			7					
			8					
			9					
			10					
			11					
			12					
			13					
			14					
			15					
			16					
			17					
			18					
		19						
		20						
I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE OF SERVICE HAVE BEEN COMPLETED						TOTAL FEE CHARGED		
_____ SIGNED (DENTIST)						PLAN PAYS		
_____ DATE						PATIENT PAYS		
FORM RETURNED TO DENTIST			BENEFIT APPROVAL BLOCK					
DATE _____ REASON _____			BY _____ DATE _____					
			TITLE _____					