ATTENDING DENTIST'S STATEMENT

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

MAIL THIS FORM TO:

HUMANADENTAL CLAIMS OFFICE
PO BOX 14611
LEXINGTON, KY 40512-4611
800-233-4013

PART I - TO BE COMPLETED BY INSURED

1. Patient Name	2. Relationship to Insured: SELF / SPOUSE / SON / DAUGHTER / OTHER	3. Sex M / F	4. Patient Birthdate MO / DAY / YEAR	5. If full time student SCHOOL / CITY
6. Insured Name First / Middle / Last			7. Insured Member Identification Number	8. Insured Birthdate MO / DAY / YEAR
9. Insured Mailing Address			10. Employer Name	
11. City, State, Zip			12. Group NO.	
13. Are other family members employed? ☐ Yes ☐ No If yes, Employee Name Soc. Sec. No. Birthdate Relationship to Patient			14. Name and Address of Employer in Item 13	
15. Is Patient Covered by another Dental Plan? Yes ☐ No ☐	If yes, Dental Plan Name	Group No.	Name and Address of Carrier	

AUTHORIZATION TO RELEASE INFORMATION -- I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to the HumanaDental Insurance Company for any oral or dental observation, treatment, services, or benefits rendered or payable to me or on my behalf. A photostat of this authorization shall be valid as the original.

SIGNED (PATIENT OR PARENT IF MINOR) _____ DATE _____

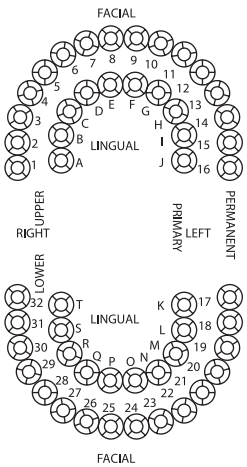
YOUR POLICY PROVIDES AUTOMATIC ASSIGNMENT OF BENEFITS TO THE DENTIST

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PART II - TO BE COMPLETED BY ATTENDING DENTIST

16. DENTIST NAME			24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter a brief descrption
17. Mailing Address			25. Is treatment result of auto accident? 26. Other accident?			
City, State, Zip			27. Are any services covered by another plan?			If yes, name of other plan:
18. Dentist TIN or Soc. Sec.	19. Dentist License No.	20. Dentist Phone No.	28. If Prosthesis is this the 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	30. Is treatment for Orthodontics?			If services already commenced, enter Date appliances placed: Mos. treatment remaining:

MISSING TEETH WITH "X"



32 REMARKS FOR UNUSUAL SERVICES

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

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIAL USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE	FOR CARRIER USE ONLY	EXPLANATION CODE

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST) _____ DATE _____

IF INSURED HAS MADE PAYMENT, PLEASE INDICATED AMOUNT $

ADDRESS WHERE TREATMENT WAS PERFORMED

CITY STATE ZIP

TOTAL FEE CHARGED	
PAYMENT BY OTHER PLAN	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

Please note: Pretreatment Review is not a guarantee of benefits payable.

This estimate advises you in advance of the amount of insurance benefits payable if the described procedures are performed during a period of the patient's eligibility.

GN-00229-HD 7/04

Please review this statement to assure that there are no discrepancies or irregularities between this and the treatment you obtained. You may notify us by using our toll free number 1-800-233-4013.
Thank you for serving HumanaDental members.