

ATTENDING DENTIST'S STATEMENT

IMPORTANT: Please use separate copies of this form for ACTUAL SERVICES and PRE-DETERMINATION purposes.
 ACTUAL SERVICES
 PRE-DETERMINATION

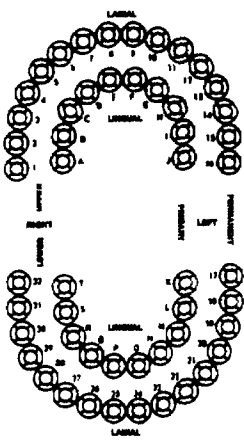
Med-Pay, Inc. P.O. Box 10909
 Springfield, MO 65808

PATIENT SECTION	1. Patient name first m.i. last	2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____	3. Sex m f	4. Patient birthdate MM DD YYYY	5. If full time student school city
	6. Employee/subscriber name and mailing address	7. Employee/subscriber soc. sec. number	8. Employee/subscriber birthdate MM DD YYYY	9. Employer (Company) Southwest Missouri State University	10. Group number 090188SMSU
	11. Is patient covered by another plan of benefits? Dental _____ Medical _____	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of employer	
	14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. number	14-c. Employee/subscriber birthdate MM DD YYYY	15. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other _____	

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.
 _____ Date _____
 Signed (Patient, or parent if minor)

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.
 _____ Date _____
 Signed (Insured person)

DENTIST SECTION	16. Dentist name	24. Is treatment result of occupational illness or injury? No Yes	If yes, enter brief description and dates.	
	17. Mailing address City, State, Zip	25. Is treatment result of auto accident? 26. Other accident?	No Yes	
	18. Dentist Soc. Sec. or T.I.N.	19. Dentist license no.	20. Dentist phone no.	27. Are any services covered by another plan? 28. If prosthesis, is this initial 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. Date of prior placement (If no, reason for replacement)

Identify missing teeth with "X" 	31. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.							For administrative use only	
	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.) Line No.	Date service performed Mo. Day Year			Procedure number		Fee

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
 _____ Date _____
 Signed (Dentist)

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	