SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND

S.C.M. EMPLOYEE BENEFIT FUND

[ ] DENTIST'S PRE-TREATMENT ESTIMATE
[ ] DENTIST'S STATEMENT OF ACTUAL SERVICES

NOTE: ALL INFORMATION MUST BE PRINTED
TREATMENT OVER $1,000 MUST BE PREAUTHORIZED

Send Completed Forms to: Healthplex, Inc.; PO Box 211672; Eagan, MN 55121

Fully insured plan (Active, COBRA & SPERP) - 1-866-717-1869
No Cost Basic Retirees- 1-866-935-9047
www.healthplex.com

1. Patient Name	2. Relationship to Subscriber Self Spouse Child Other	3. Sex M F	4. Patient Birth date	5. Fulltime Student Y N School City

6. Subscriber Name: First Middle Last	7. Subscriber Social Security or ID Number	8. Subscriber Date of Birth

9. Subscriber Mailing Address	City	State	Zip

10. Group No.	11. Are Other Family Members Employed? Y N Employee Name Soc. Sec. No.	12. Date of Birth	13. Name and Address of Employer in Item 11

14. Is Patient Covered by Another Dental Plan? Y N	15. Dental Plan Name Policy # Name and Address of Carrier

16. I certify that I have read and understand the eligibility requirements for this program as described in the plan and that the patient for whom the claim is made is eligible for benefits. I further certify that neither I nor any of my dependents is covered by any other enrollment in a group dental insurance program, except as noted. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signed (Patient or Guardian) _____ Date _____

To Be Completed By Dentist

	17. Procedure Date	18. Area of Oral	19. Tooth #(s) / Letter(s)	20. Tooth	21. Procedure Code	22. Description	23. Fee	24. Administrative
1								
2								
3								
4								
5								
6								
7								
8								
9								
10.								
11.								

25. Place an "X" on each missing	1 2 3 4 5 6 7 8 / 32 31 30 29 28 27 26 25	9 10 11 12 13 14 15 16 / 24 23 22 21 20 19 18 17	A B C D E / T S R Q P	F G H I J / O N M L K	26. Other fee(s)		
28. **Remarks**					27. Total Fee		

AUTHORIZATIONS

29. I have been informed of the treatment plans and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. I understand that benefits will automatically be assigned to my dentist if he or she is a SCMEBF PPO Provider.

X _____
Patient/Guardian signature Date

30. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity, if allowed under my group guidelines. I understand that benefits will automatically be assigned to my dentist if he or she is a SCMEBF PPO Provider.

X _____
Subscriber signature Date

ANCILLARY CLAIM TREATMENT INFORMATION

31. Place of Treatment (Check applicable box)
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

32. Number of Enclosures
Radiographs(s) [ ] Oral Image(s) [ ] Model(s) [ ]

33. Is Treatment for Orthodontics?
☐ No (Skip **34-35**) ☐ Yes (Complete **34-35)**

36. Replacement of Prosthesis?
☐ No ☐ Yes (Complete 37)

34. Date Appliance Placed (MM/DD/YY) 35. Months of Treatment Remaining

37. Date Prior Placement (MM/DD/YY)

38. Treatment Resulting from (Check applicable box)
☐ Occupational Illness/injury ☐ Auto Accident ☐ Other accident

39. Date of Accident (MM/DD/YY) 40. Auto Accident State

41. **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

Name, Address, City, State, Zip Code

42. Provider ID | 42A. NPI # | 43. License Number

44. SSN or TIN | 45. Phone Number ( )

46. TREATING DENTIST AND TREATMENT LOCATION INFORMATION

I hereby certify that the procedure(s) as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submited are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) Date

47. Provider ID | 47A. NPI# | 48. License Number

49. Address, City, State, Zip Code

50. Phone Number ( ) | 51. Treating Provider Specialty