Dental Claim Statement

Sun Life Financial®

Check one: ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services

PATIENT COVERAGE INFORMATION

1 Patient name First M.I. Last	2 Relationship to employee ☐Self ☐Child ☐Spouse ☐Other_____	3 Sex M F	4 Patient birthdate MO DAY YR	5 If full-time student School City
6 Employee/subscriber name and mailing address	7 Employee/subscriber Soc. Sec. or I.D. no.	8 Employee/subscriber birthdate MO DAY YR	9 Employer (company) name and address Nyack Union Free School District	10 Group number 954573
11 Is patient covered by another dental plan? ☐Yes ☐No If "Yes," complete 12-a. Is patient covered by a medical plan? ☐Yes ☐No	12-a Name and address of carrier(s)	12-b Group no(s).	13 Name and address of other employer(s)	
14-a Employee/subscriber name *(if different than patient's)*	14-b Employee/subscriber Soc. Sec. or I.D. no.	14-c Employee/subscriber birthdate MO DAY YR	15 Relationship to patient ☐Self ☐Parent ☐Spouse ☐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. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named entity. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form allowing Union Security Life Insurance Company of New York and Sun Life and Health Insurance Company (U.S.) to use and disclose protected health information. I have read or had read to me the fraud warning for my state.

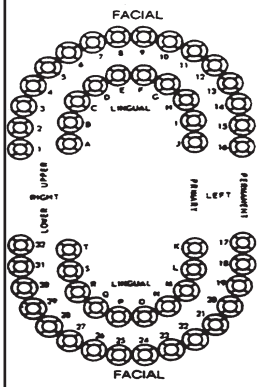
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

▶ **SIGNED (PATIENT OR PARENT, IF MINOR)** **DATE** ▶ **SIGNED (INSURED PERSON)** **DATE**

BILLING DENTIST

16 Name of Billing Dentist or Dental Entity			24 Is treatment result of occupational illness or injury?	No	Yes	If "Yes," enter brief description and dates.
17 Address where payment should be remitted			25 Is treatment result of auto accident?			
City, State, Zip			26 Other accident?			
18 Dentist Soc. Sec. or TIN	19 Dentist license no.	20 Dentist phone no.	27 If prosthesis, is this initial placement?			If "No," reason for replacement / 28 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**"



30 Examination and treatment plan—List in order from tooth no. 1 through tooth no. 32—Use charting system shown.

Tooth # or letter	Surface	Description of Service *(including x-rays, prophylaxis, materials used, etc.)*	Date Service Performed Mo Day Year	Procedure Number	Fee

31 Remarks for unusual services

For administrative use only

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. I have read or had read to me the fraud warning for my state. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNED (TREATING DENTIST) LICENSE NUMBER DATE

Total Fee

Charged

Max. allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

Insurance products are underwritten by Union Security Life Insurance Company of New York (Fayetteville, NY) and Sun Life and Health Insurance Company (U.S.) (Lansing, MI) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

Sun Life Financial PO Box 2941 Clinton Iowa 52733

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