J. J. STANIS
and COMPANY, INC.

To access additional claim forms, please visit our website at:
www.jjstanisco.com

DENTAL CLAIM FORM

INSTRUCTIONS

1. You must FULLY COMPLETE the EMPLOYEE'S STATEMENT - Part A and SIGN IT.
2. Attach bills for dental benefits you are claiming. These bills must be itemized and show the patient's name, condition being treated (diagnosis), type of treatment given, date expense was incurred and individual charges made.
3. A DENTIST'S Statement is provided on the back of this form.
4. When completed return this form to: J. J. STANIS and COMPANY, INC
   377 Oak Street, Suite 406
   Garden City, NY 11530 877 470 3715

PART A – EMPLOYEE'S STATEMENT

FULLY COMPLETE FOR ALL CLAIMS

Employee's Name (Please Print)	**Group #** 009980	Your Date of Birth	Social Security Number

Address: Street and No. City State Zip Code

Phone Number

This claim is on: 0 Myself 0 Spouse 0 Dependent Child

Are you, married? 0 Yes 0 No Is Spouse employed 0 Yes 0 No

If Spouse is employed, His or Her name _____ and Soc. Sec. No. ____/____/____
Name, address & phone number of company where he/she is employed

Company Name_____ Telephone No.

Address

What was the sickness or injury?	On what date did it begin?	Date of first expense for this condition

Are Benefits payable from any other source (including Military, Automobile, Liability Insurance, School Accident Insurance) for the expense submitted? If "Yes", (a) Other Source:

(b) Address:

0 Yes 0 No c) Policy No. or I.D. No.

COMPLETE FOR ALL INJURIES

Date of Injury?	Where did the injury occur?	How did the injury occur?

Is the injury due to automobile accident? ρ Yes ρ No

Has or will claim be filed under any Workmen's Compensation Act or similar law? 0 Yes 0 No

COMPLETE ONLY FOR DEPENDENT CLAIMS

Name of Dependent	Date of Birth	Relationship to Employee	0 Married 0 Single

If employed or attending school give the name of employer or school :

Name_____ Telephone No.

Address

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer or Organization to release any information regarding the medical or dental history, treatment or benefit payable for this claim to J. J. STANIS and COMPANY, INC. for the purpose of validating and determining benefits payable in connection with this claim. This authorization or photostatic copy of the original shall be valid for one year from the date of signature. Data may be extracted for statistical, audit, and verification purposes. I understand that I may request to receive a copy of this authorization.

Employee and Patient (Parent if minor) Date

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, Insurance company, or self insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

PART B - ATTENDING DENTIST STATEMENT

Type or Print

PATIENT & COVERED EMPLOYEE (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S SEX
MALE 0 FE MALE 0

MAIL THIS FORM TO:

J. J. STANIS and COMPANY, INC.
377 Oak Street, Suite 406
Garden City, NY 11530

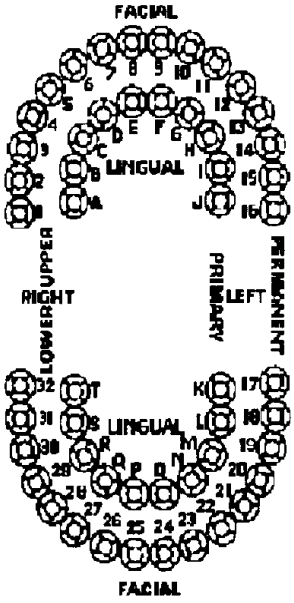
AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named Dentist of the Group Dental Benefits payable to me.

EMPLOYEE'S SIGNATURE DATE

3. DENTIST NAME	4. Is treatment result of occupational illness or injury?	NO	YES	If "Yes" enter brief description and dates.
10. MAILING ADDRESS	5. Is treatment result of auto accident? 6. Other accident?			
CITY, STATE, ZIP	7. Are any services covered by another plan?			If "Yes", name of other plan
11. DENTIST SOC. SEC. OR TIN / 12. DENTIST LICENSE. NO. / 13. DENTIST PHONE NO.	8. If prostheses, is the initial placement?			If "No", reason for replacement / 29. Date of Prior placement?
14. FIRST VISIT DATE CURRENT SERIES / 15. PLACE OF TREATMENT Office |Hosp |ECF |Other / 16. RADIOGRAPHS OR MODELS ENCLOSED NO YES HOW MANY?	9. Is treatment for orthodontics?			IF SERVICES ALREADY COMMENCED, ENTER: Date appliances placed | Mos. Treatment remaining

CHECK ONE: 0 **DENTIST'S PRETREATMENT ESTIMATE** 0 **DENTIST'S STATEMENT OF ACTUAL SERVICES**

Identify missing teeth with "X"



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

TOOTH # OR LETTER	SURFACE (i.e. M,O, D,B.L.LA,I)	DESCRIPTION OF SERVICE (including x-rays, prophylaxis, materials used, etc)	DATE SERVICE PERFORMED MO	DAY	YEAR	PROCEDURE NUMBER	FEE	
18. REMARKS FOR UNUSUAL SERVICE								

I hereby certify that the procedures as indicated by date have been completed.

Date

SIGNED (Dentist)

TOTAL FEE CHARGED		
MAXIMUM ALLOWABLE		
DEDUCTIBLE		
CARRIER PERCENTAGE		
CARRIER PAYS		
PATIENT PAYS		