EMPLOYER PLAN SERVICES, INC.

Please mail the completed form to:

EMPLOYER PLAN SERVICES, INC.
2180 North Loop West, Suite 400
Houston, Texas 77018
(713) 932-8917 / (800) 447-6588

EMPLOYER NAME	GROUP NUMBER

A. EMPLOYEE SECTION
(Always complete this section)

1. EMPLOYEE'S NAME	2. SOCIAL SECURITY NUMBER

3. ADDRESS	4. CITY	5. STATE	6. ZIP

7. THIS CLAIM IS FOR:
- ❑ EMPLOYEE (FILL OUT SECTIONS 3, 4, & 5)
- ❑ DEPENDENT (ANSWER ALL SECTIONS)

B. ABOUT THE DEPENDENT
(Complete only if patient is a dependent)

8. DEPENDENT'S NAME	9. BIRTHDATE	10. RELATIONSHIP
		❑ SPOUSE ❑ STEPCHILD ❑ CHILD ❑ _____

11. SOC. SEC. NO.	12. If full time student, name and location of school

C. OTHER COVERAGE
(Always complete this section)

13. Is the patient covered by another dental plan?	14. If "YES", name and social security # of covered person	15. If "YES", name of the employer and carrier or plan
❑ YES Complete this section → ↓ ❑ NO		

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

X _____
Signed(Patient, or Parent if minor) Date

I hereby authorize payment directly to the below named dentist, the group insurance benefits otherwise payable to me. I understand that I am financially responsible for payment. Any insurance payments will be applied towards the balance.

X _____
Signed(Patient, or Parent if minor) Date

16. DENTIST NAME	24. Is treatment result of occupational illness or injury?	YES	Leave blank if NO, otherwise mark YES If YES, enter brief description and dates
17. STREET NAME	25. Is treatment result of auto accident?		
	26. Other accident?		
CITY, STATE ZIP	27. Are any services covered by another plan?		
18. DENTIST (SOC. SEC. OR T.I.N.) 19. DENTIST LIC. NO. 20. DENTIST PHONE NO.	28. If prostheses is this initial placement?		Reason for replacement 29. Date of prior placement
21. First Visit Date 22. Place of Treatment 23. Are Radiographs Enclosed - How Many? If YES, Indicate Y, otherwise leave blank.	30. Is treatment for orthodontics?		Date appliances placed Mos. treatment remaining

IDENTIFY MISSING TEETH

UPPER
08 09
07 10
06 11
05 E F 12
04 D G 13
03 C H 14
02 B I 15
01 A J 16
RIGHT LEFT
32 T K 17
31 S L 18
30 R M 19
29 Q N 20
28 P O 21
27 22
26 23
25 24
LOWER

31. EXAMINATION & TREATMENT PLAN Using charting system as shown (#1 is upper right 3rd molar, #32 is lower right 3rd molar)

Tooth # or Letter	Surface	DESCRIPTION OF SERVICES	Date Performed Mo. Day Year	Procedure Number	FEE	Administration Use Only

32. REMARKS FOR UNUSUAL SERVICES.

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

Signed (Dentist) _____ Date _____

Total Fee Charged