

**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  
100 Jericho Quadrangle, Suite 101  
Jericho, NY 11753 877 470 3715

PART A – EMPLOYEE'S STATEMENT					
<b>FULLY COMPLETE FOR ALL CLAIMS</b>	Employee's Name (Please Print)		<b>Group #</b>	Your Date of Birth	Social Security Number
	Address: Street and No.		City	State	Zip Code
	Phone Number		This claim is on: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child		
	Are you, married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Spouse employed <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____				
<b>COMPLETE FOR ALL INJURIES</b>	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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", (a) Other Source: _____ (b) Address: _____ c) Policy No. or I.D. No. _____				
	Date of Injury?	Where did the injury occur?	How did the injury occur?		
Is the injury due to automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Has or will claim be filed under any Workmen's Compensation Act or similar law? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>COMPLETE ONLY FOR DEPENDENT CLAIMS</b>	Name of Dependent		Date of Birth	Relationship to Employee	<input type="checkbox"/> Married <input type="checkbox"/> Single
	If employed or attending school give the name of employer or school : Name _____ Telephone No. _____ Address _____				
	<p><b>AUTHORIZATION TO RELEASE INFORMATION:</b> 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.</p>				
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.

