

**HEALTHPLEX, INC.**



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

**DETECTIVE ENDOWMENT ASSOCIATION**

Send Completed Forms to: Healthplex, Inc.  
 333 Earle Ovington Blvd., Suite #300, Uniondale, NY 11553-3608  
 Providers Call – (888) 468-2183 Press Option # 3  
 Members Call – (800) 468-0600 Press Option # 1  
 www.healthplex.com  
 Email: info@healthplex.com

1. Patient Name			2. Relationship to Subscriber Self Spouse Child Other			3. Sex M F		4. Patient Birthdate		5. Fulltime Student School City Y N	
6. Subscriber Name First Middle Last					7. Subscriber Social Security Number			8. Subscriber Date of Birth			
9. Subscriber Mailing Address City, State, Zip											
10. Group No. <b>D.E.A.</b>		11. Are Other Family Members Employed? Employee Name Soc. Sec. No. Y N			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 (By Subscriber Only) \_\_\_\_\_ Date \_\_\_\_\_

↓ To Be Completed By Dentist ↓

17. Procedure Date (MM/DD/YY)	18. Area of Oral Cavity	19. Tooth #(s) / Letter(s)	20. Tooth Surface	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 tooth		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	26. Other fee(s)	
		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

28. Remarks		27. Total Fee
-------------	--	---------------

<b>AUTHORIZATIONS</b>		<b>ANCILLARY CLAIM TREATMENT INFORMATION</b>	
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.  X _____ N/A _____ Patient/Guardian signature Date		31. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other	
30. _____		32. Number of Enclosures Radiographs(s) Oral Image(s) Model(s) [ ] [ ] [ ]	
X _____ N/A _____ Subscriber signature Date		33. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 34-35) <input type="checkbox"/> Yes (Complete 34-35)	
31. _____		34. Date Appliance Placed (MM/DD/YY) 35. Months of Treatment Remaining	
32. _____		36. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 37)	
33. _____		37. Date Prior Placement (MM/DD/YY)	
34. _____		38. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other accident	
35. _____		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		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 visit(s) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. X _____ Signed (Treating Dentist) - Date	
42. Provider ID		47. Provider ID	
43. License Number		48. License Number	
44. SSN or TIN		49. Address, City, State, Zip Code	
45. Phone Number ( )		50. Phone Number ( )	
		51. Treating Provider Specialty	

**IMPORTANT:**

"Any person who knowingly and with intent to defraud any insurance company or other person files a 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."

**PLEASE REVIEW BEFORE SUBMITTING CLAIMS**

**INSTRUCTIONS FOR MEMBERS:**

1. Complete items 1 through 15 in full to assure positive and prompt payment. Please print or type.
2. The subscriber must sign and date the claim.
3. Dental coverage is subject to specific limitations and exclusions.
4. THIS FORM WILL BE RETURNED IF IT IS INCOMPLETE OR INCORRECT.

**INSTRUCTIONS FOR DENTIST:**

Predetermination advised for \$250 or more, x-rays must be attached.

Claim settlements will be issued directly to the employee/member. Assignment of benefits will not be honored.

Generally, x-rays will not be required pre-operatively when the treatment plan involves only the use of Amalgam, Plastic, Silicate or Composite Restorations.

Diagnostic x-rays should be submitted for all other treatment. A pre-operative and post-operative x-ray is required where endodontic treatment has been rendered.

**REMARKS FOR UNUSUAL SERVICES:**

---

---

---

---

---

---

---

---

Mail completed Form to:



333 Earle Ovington Blvd., Suite 300  
Uniondale, NY 11553-3608

Members Only Call Customer Service 1- 800-468-0600 Press Option 1  
Providers Only Call Provider Hot Line 1- 888-468-2183 Press Option 3

www.healthplex.com  
E-Mail: info@healthplex.com