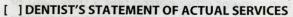
HEALTHPLEX, INC.

[] DENTIST'S PRE-TREATMENT ESTIMATE

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

						ionship to Subscriber Spouse Child Other		3. Sex M F		4. Patient Birthdate			5. Fulltime Student Y N School City N			
6. 9	Subscriber Name				1			7. Subscriber Social Security Number				8. Subscriber Date of Birth				
First Middle Walter Last Parallel Middle 100 Hord								I through 15 in Juli 10 assure positive and					O. Subscriber Date of Birth			
9. 9	9. Subscriber Mailing Address City, State, Zip															
	3. Dental coverage is subject to specific limitations and exclusions.															
10.	Group No.			Members Em		N	12. Date of Birth 13. Name and Address of Employer in Item 11									
D.E.A. Employee Name Soc. Sec. No.					4. THIS FORM WILL BE RETURNED IT IS INCOMPLETE ON IN											
14. Is Patient Covered by Another Dental Plan? Y N 15. Dental Plan Name Policy #						INSTRUCTIONS FOR DENTIST:										
furt	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. **Additional Section 11 of the plan and plant plan															
Sig	ned (By Subscril	ber Only)						_		С	ate					
Impolent in our last vian souloupi agle troopiums ads a							ompleted E	ompleted By Dentist •								
	17. Procedure	18. Area	19. Tooth		21.		22. Description						23. Fee		24.	
	Date (MM/DD/YY)	of Oral Cavity	#(s) / Letter(s)	Tooth Surface	Procedure Code										Administrative	
1	Dispersion of	- Curity	2000(3)	EUG DI	- operative	719 A	eatmen	na roniro	the suit	mittee	diz s	u bluo n	E KET K.	100	Pied	
2								.001	obnet	nood a	ni ing	traiss d	zi nobej	193	softe.	
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8																
9						-				Y						
10.																
11.														-		
25.	Place an "X" on	1 2	3 4 5	6 7 8	9 10 11 12	13 14 1	15 16 A	B C D	EF	G H	I J	26. Othe		-		
	each missing tooth			27 26 25	24 23 22 21			S R Q	PO		LK	fee(s)				
28. Remarks							s 17 1	3 " Q	110		- K	27. Total Fee				
ΔU	THORIZATIONS		(ANCULA	RY CLAIM TR	EATMENT	LINEODMA	TION	ree				
		of the treatme	nt plans and	associated fee	s Lagree to be respon	sible for all					IION					
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 practed health information to compute the promoter of the properties with the description.												32. Number of Enclosures Radiographs(s) Oral Image(s) Model(s) [] [] []				
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							33. Is Treatment for Orthodontics? No (Skip <u>34-35</u>) Yes (Complete <u>34-35</u>)						36. Replacement of Prosthesis? No Yes (Complete 37)			
Patient/Guardian signature Date							34. Date Appliance Placed (MM/DD/YY) 35. Months of Treatment Remaining 37.						7. Date Prior Placement (MM/DD/YY)			
					Suite 300	Blvd.,	38 Treatm	ent Resulting f	rom (Charl	k applicable l	nox)					
11553-3608 x						N N N S N N N N N N N N N N N N N N N N	upational Illnes	4	Auto			ther accident				
		N/	Α						, ,					ant State		
Subscriber signature Date						J. Date Of	39. Date of Accident (MM/DD/YY) 40. Auto Accident State									
41. E	on behalf of the patie	DR DENTAL E	NTITY (Leaves	ve blank if dentis	t or dental entity is not	t submitting		TING DENTIS								
claim on behalf of the patient or insured/subscriber) Name, Address, City, State, Zip Code						I hereby certify that the procedure(s) as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.										
							x									
olex.com							Signed (Treating Dentist)					· Date				
lthplex.com								47. Provider ID 48. License Number					ense Number			
42. Provider ID 43. License Number							49. Address, City, State, Zip Code									
44. SSN or TIN				. Phone Numbe	r ()	50. Phone	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.

RFM.	ARKS	FOR	UNUSU	JAI	SFRV	CFS.
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Mail completed Form to:



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

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

1-888-468-2183 Press Option 3

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