

For additional dental claim forms,
Please visit our website:
www.jjstanisco.com

Mail completed forms to:
J.J. STANIS AND COMPANY, INC
377 Oak Street, Suite 406 * Garden City, New York 11530
Phone: 516-465-3900 Fax 516-465-3920

To Be Completed by Employee

Dental Expense Claim

1. Patient First Name Middle Last			2. Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Patient Date of Birth Mo. / Day / Year	6. For Office Use
7. If Full-Time Student (Age 19 or Over) School City State			8. ID Number		9. If Disabled (Age 19 or Over) <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Name of Group Dental Program	
11. Employee First Name Middle Last			12. Employee Date of Birth		13. Office Phone (Area Code)			
14. Employee Residence Mailing Address			15. City State ZIP					
16. Are other Family Members Employed? Name <input type="checkbox"/> Yes <input type="checkbox"/> No Social Security / ID Number			17. Date of Birth		18. Name and Address of Employer for item 16			
19. Is Patient Covered by Another Dental Plan? Dental Plan Name <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete the following:)			Name and Address of Carrier Group No.					
20. I Authorize Release of any Information Relating to this Claim. (Signature of Patient or Signature of _____ Date _____ Authorized Representative if Minor) If Authorized Representative, Relationship to Minor _____			21. I Certify that the Above Information is Correct. Employee Signature _____ Date _____		22. I Authorize Payment Directly to the Below-Named Dentist. Employee Signature _____ Date _____			

To Be Completed by Dentist

23. Dentist Name		24. Mailing Address City State ZIP	
25. Dentist Phone Number	26. Dentist License Number	27. Dentist SSN or T.J.N.	28. Provider Specialty Code
29. NPI (Treating Dentist)	30. NPI (Billing Entity, if different)		31. First Visit Date Current Series
32. Place of Treatment <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other		33. Radiographs or Models Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No How Many?	
34. Is Treatment Result of Occupational Illness or Injury? (If Yes, Enter Brief Description and Dates) <input type="checkbox"/> Yes <input type="checkbox"/> No		35. Is Treatment Result of Auto Accident? (If Yes, Enter Brief Description and Dates) <input type="checkbox"/> Yes <input type="checkbox"/> No	
36. Other Accident? (If Yes, Enter Brief Description and Dates) <input type="checkbox"/> Yes <input type="checkbox"/> No		37. Are any Services Covered by Another Plan? (If Yes, Enter Brief Description and Dates) <input type="checkbox"/> Yes <input type="checkbox"/> No	
38. If Prosthesis, is this Initial Placement? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, Reason for Replacement)			39. Date of Prior Replacement
40. Is Treatment for Orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Services Already Commenced, Enter Date Appliance Placed		Months of Treatment Remaining
Dentist's <input type="checkbox"/> Pretreatment Estimate <input type="checkbox"/> Statement of Actual Services (Be sure to sign below)*			

41. Examination and Treatment Plan - List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)							
<p>INDICATE MISSING TEETH WITH AN "X"</p>	Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo./ Day /Year	ADA Procedure Number	Fee	For Carrier Use Only

42. I Herby Certify That The Services Listed Above <input type="checkbox"/> Will Be <input type="checkbox"/> Have Been Performed.			Total Fee Actually Charged
*Signature of Dentist _____		Date Signed _____	
43. Address where treatment was performed Street _____		City _____	State _____ ZIP _____