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DENTIST STATEMENT OF CLAIM
NATIONAL HOCKEY LEAGUE

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

INSURED INFORMATION

Patient Name | Relationship to Employee

Sex | Date of Birth Day/Month/Year | If full time student, state school and city

Employee Name

Address

Team | Group | Group No.

Employer's Name and Address

Are any other family members employed? YES/NO | If yes, state name and Social Security Number

Is patient covered by another dental plan? YES/NO | If yes, state dental plan name, group no. and name and address of carrier

I have reviewed the following treatment plan and I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signed (Patient or parent if minor) Date

I hereby assign my benefits payable from this claim to the named Dentist and authorize payment directly to him/her.

Signed (Insured Person) Date

DENTIST INFORMATION

Dentist's Name, Address, Phone No. and Social Security No. or TIN

First visit date for current series | Place of treatment: Office / Hosp / ECF / Other | Radiographs or models enclosed? YES/NO | How many?

	No	Yes	
Is treatment result of occupational illness or injury?			If yes, enter brief description and dates
Is treatment result of an auto accident or other accident?			If yes, enter brief description and dates
If prosthesis, is this an initial placement?			If no, reason for replacement and date of prior placement
Is treatment for orthodontics?			Enter date of initial placement and months of treatment remaining

DATE	TOOTH NO.	SURFACE	DESCRIPTION OF SERVICE INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED ETC. LINE NO.	PROCEDURE NO.	FEE	FOR ADMIN. USE

TOTAL FEE SUBMITTED

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Dentist) Date