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Employee Section	Plan Number G- 321504
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1. Patient's name	Relation to employee	Social Security No. <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's birthdate	If full-time student, School	City	
2. Employee's name		Social Security No.	Birthdate			
3. Employee's address		(Check here if new address <input type="checkbox"/>)	City	State	ZIP	
4. Is spouse or patient employed?		Name & address of employer	Social Security No.	Spouse's birthdate		
5. Is patient covered by another Dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please give:						
Carrier name		Address		Plan No.		
6. I authorize payment to the dentist named below of the dental benefits otherwise payable to me						
Signature of employee _____			Date _____			
7. I authorize any provider, insurer, or other organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.						
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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. In New York the person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. In California, any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.						
Signature of employee _____		Signature of patient if other than minor child _____		Date _____		

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Dentist Section	1. Soc. Sec. No. or TIN License No. Phone No.			2. Dentist's name & complete address		
3. First visit date current series	Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other	Radiograms enclosed? If "Yes," how many? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. Is treatment result of occupational illness or injury? If "Yes," enter brief description and dates. <input type="checkbox"/> Yes <input type="checkbox"/> No						
5. Is treatment a result of auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		6. Are services covered by another plan? If "Yes," give name of plan. <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. If prosthesis, is this initial placement? If "No," give reason for replacement. Give date of prior placement. <input type="checkbox"/> Yes <input type="checkbox"/> No						
8. Is treatment for orthodontics? If "Yes," and services already commenced, give date appliances placed. Give months of treatment remaining. <input type="checkbox"/> Yes <input type="checkbox"/> No						
9. Examination and treatment plan: list in order from tooth no. 1 through tooth no. 32 and use the charting system shown. Check one: <input type="checkbox"/> Dentist's pre-treatment estimate (date) _____ <input type="checkbox"/> Statement of actual services						
10. Indicate missing teeth with an "x"	Tooth No. or letter	Surface (M, O, D, B, L, LA, I)	Description of service (including xrays, prophylaxis, material used, etc.)	Date service completed Mo. Day Yr.	Procedure Number	Fee
11. Remarks for unusual service						
I certify that the procedures as indicated by date have been completed and that the fees indicated are those actually charged the patient regardless of the existence of insurance coverage.				Total Fee		
Dentist's signature _____		Date _____				

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From: _____



Place
Stamp
Here

ONONDAGA EMPLOYEE LEASING SERVICE, INC.
PLAN NO. G-321504 RGO 20



THE GUARDIAN
DENTALGUARD PREFERRED
P O BOX 2459
SPOKANE WA 99210-2459



INSTRUCTIONS FOR THE EMPLOYEE

- ❖ ***Please answer all questions in the Employee Section.***
- ❖ ***Sign & date the authorization to release information.***
- ❖ ***If you want us to pay your benefits directly to the dentist, sign and date question number 6. If authorized, we will make payment directly to your dentist and send a copy of the payment to you for your records. Otherwise, we will pay you directly.***

For DentalGuard Customer Service, call 800-541-7846 OR 509-468-6500

INSTRUCTIONS FOR THE DENTIST

Submit a claim for each new course of treatment either by completing a new DentalGuard Claimvelope or by sending us an itemized statement of services. Make certain that your patient's name is on the claimvelope or itemized statement.

CLAIMS OF LESS THAN \$200:

- ❖ ***Complete the Dentist Section itemizing charges for each procedure.***
- ❖ ***Fold and seal the form to create an envelope and send it to Guardian.***

NON-EMERGENCY CLAIMS EXPECTED TO EXCEED \$200:

- ❖ ***Complete the Dentist Section itemizing charges for each proposed procedure. The form serves as your pre-treatment plan.***
- ❖ ***To avoid loss, mail this form and pre-treatment x-rays together in one envelope.***