Healthplex®
Leadership in Dental Plans

[ ] Pre Treatment Estimate
[ ] Statement of Actual Services

MAIL THIS CLAIM FORM PROMPTLY TO
HEALTHPLEX, INC.
333 EARLE OVINGTON BLVD., SUITE 300
UNIONDALE, NY 11553-3608
MEMBERS ONLY – 1-800-468-0600 PRESS OPTION 1
PROVIDERS ONLY - 1-800-468-2183 PRESS OPTION 3
www.healthplex.com E-Mail info@healthplex.com

DETECTIVE ENDOWMENT ASSOCIATION

1. Patient Name	2. Relationship to Subscriber Self Spouse Child Other	3. Sex M F	4. Patient Birthdate	5. Fulltime Student School City

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 D.E.A.	11. Are Other Family Members Employed? Employee Name Soc. Sec. No.	12. Date of Birth	13. Name and Address of Employer in Item 11

14. Is Patient Covered by Another Dental Plan?	15. Dental Plan Name	Policy #	Name and Address of Carrier

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Signed (Patient, or Parent if Minor) ______________________ Date ______________________

To Be Completed By Dentist

		No	Yes	
16. Dentist Name	24. Is Treatment Result of Occupational Illness Or Injury?			IF Yes, Give Brief Description and Dates
17. Mailing Address	25. Is Treatment Result of Auto Accident? 26. Other Accident?			
City, State, Zip	27. Are Any Services Covered By Another Plan?			
18. Dentist(Soc.Sec. Or T.I.N.) 19. Dentist License # 20. Dentist Phone #	28. If Prosthesis, Is This Initial Placement?			(If No Reason For Replacement) 29. Date of Prior Placement

21. First Visit Date Current Series	22. Place of Treatment Office/Hosp/ECF/Other	23. Radiographs Or Models Enc.?	No	Yes	How Many?	30. Is treatment for Orthodontics?			If Services Already Commenced Enter	Date Appliances Placed	Mos Tx Remaining?

31. Examinations and Treatment Plan - List In Order From Tooth No. 1 Through Tooth No. 32. - Use Charting System Shown

Identify Missing Teeth with "X"	Tooth # or Letter	Surface	Description of Service (Including X-Rays, Prophylaxis, Materials used, etc.) Line No.	Date Service Performed Mo Day Yr	Procedure Number	Fee	For Administrative Use Only
FACIAL			1.				
			2.				
			3.				
			4.				
LINGUAL			5.				
			6.				
			7.				
			8.				
LINGUAL			9.				
			10.				
			11.				
			12.				
FACIAL			13.				
			14.				

I Hereby Certify That The Procedures As Indicated By Date Have Been Completed

Total Fee Charged ______________

______________________ Date ______________________
(Signed - Dentist)

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 member 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

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Mail Completed Form to: (Please note we are moving from 60 Charles Lindbergh Blvd.)

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F 2013 PRINT 04/05 REV 04/05