ATTENDING DENTIST'S STATEMENT

Please return to:
EBSO, Inc.
P.O. Box 928
Findlay, OH 45839
800-558-7798 Customer Service
Electronic Payor ID Number: 37257

CHECK ONE:

_____ **DENTIST'S PRE-TREATMENT ESTIMATE**

_____ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

EBSO Expert Benefit Solutions

1. EMPLOYEE NAME			2. SOCIAL SECURITY NO.
3. ADDRESS	CITY	STATE OR PROVINCE	ZIP

4. PATIENT NAME (If a Dependent)	5. RELATIONSHIP TO EMPLOYEE	6. BIRTH DATE	7. DATE FIRST VISIT (Current Series)

8. EMPLOYER NAME	9. DOES PATIENT HAVE OTHER DENTAL COVERAGE? ____YES ____NO If Yes, Please Identify:
10. GROUP DENTAL PLAN NAME	11. GROUP NO.

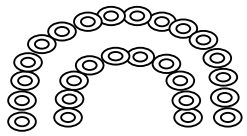
12. DENTIST'S NAME (Print)	13. LICENSE NO.	14. INDIVIDUALS PRACTITIONERS - SS# _____ ALL OTHERS - EMPLOYER I.D. # _____ Must Be Furnished Under Authority of Law
15. ADDRESS CITY STATE OR PROVINCE ZIP		

16. IS ANY OF THE TREATMENT FOR: (a) ORTHODONTIC PURPOSES? ____YES ____NO	(b) ACCIDENTAL INJURY? ____YES ____NO	(c) OCCUPATIONAL INJURY? ____YES ____NO
17. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ____YES ____NO If No, Reason for Replacement: DATE TEETH WERE EXTRACTED:	18. DATE OR PRIOR PLACEMENT:	19. ARE X-RAYS ENCLOSED? ____YES ____NO If Yes, How Many?

EXAMINATION AND TREATMENT RECORD - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DATE SERVICE DONE	ADA PROCEDURE NUMBER	FEE	FOR ADMIN. USE ONLY

LABIAL



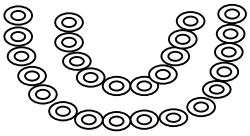
LINGUAL

UPPER

RIGHT LEFT

LOWER

LINGUAL



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INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES

ORTHODONTICS: (give diagnosis, class of malocclusion and describe appliance(s) in above treatment section)

DATE FIRST APPLIANCE INSERTED _____

DATE LAST APPLIANCE REMOVED _____

TREATMENT PERIOD (Number Months) _____

TOTAL FEE $_____

TOTAL FEE ACTUALLY CHARGED		
PATIENT PAYS		
BALANCE		
CARRIER%		
CARRIER PAYS		

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

_____ DATE: _____

SIGNED (PATIENT, OR PARENT IF MINOR)

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE____ HAVE BEEN____ PERFORMED.

_____ DATE: _____

SIGNED (DENTIST)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

_____ DATE: _____

SIGNED (INSURED PERSON)