HEALTHPLEX, INC.

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

DETECTIVE ENDOWMENT ASSOCIATION

Send Completed Forms to: Healthplex, Inc.
333 Earle Ovington Blvd., Suite #300, Uniondale, NY 11553-3608
Providers Call – (888) 468-2183 Press Option # 3
Members Call – (800) 468-0600 Press Option # 1
www.healthplex.com
Email: info@healthplex.com

1. Patient Name	2. Relationship to Subscriber Self Spouse Child Other	3. Sex M F	4. Patient Birthdate	5. Fulltime Student Y N 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 No. **D.E.A.**	11. Are Other Family Members Employed? Y N 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? Y N	15. Dental Plan Name	Policy #	Name and Address of Carrier	

16. I certify that I have read and understand the eligibility requirements for this program as described in the plan and that the patient for whom the claim is made is eligible for benefits. I further certify that neither I nor any of my dependents is covered by any other enrollment in a group dental insurance program, except as noted. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signed (By Subscriber Only) _____ Date _____

To Be Completed By Dentist

	17. Procedure Date (MM/DD/YY)	18. Area of Oral Cavity	19. Tooth #(s) / Letter(s)	20. Tooth Surface	21. Procedure Code	22. Description	23. Fee	24. Administrative
1								
2								
3								
4								
5								
6								
7								
8								
9								
10.								
11.								

25. Place an "X" on each missing tooth																					26. Other fee(s)		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	

28. **Remarks** 27. Total Fee

AUTHORIZATIONS

29. I have been informed of the treatment plans and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim

X N/A
Patient/Guardian signature Date

30.

X N/A
Subscriber signature Date

ANCILLARY CLAIM TREATMENT INFORMATION

31. Place of Treatment (Check applicable box)
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

32. Number of Enclosures
Radiographs(s) [ ] Oral Image(s) [ ] Model(s) [ ]

33. Is Treatment for Orthodontics?
☐ No (Skip **34-35**) ☐ Yes (Complete **34-35**)

36. Replacement of Prosthesis?
☐ No ☐ Yes (Complete 37)

34. Date Appliance Placed (MM/DD/YY) 35. Months of Treatment Remaining

37. Date Prior Placement (MM/DD/YY)

38. Treatment Resulting from (Check applicable box)
☐ Occupational Illness/injury ☐ Auto Accident ☐ Other accident

39. Date of Accident (MM/DD/YY) 40. Auto Accident State

41. **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)
Name, Address, City, State, Zip Code

42. Provider ID 43. License Number

44. SSN or TIN 45. Phone Number ( )

46. TREATING DENTIST AND TREATMENT LOCATION INFORMATION

I hereby certify that the procedure(s) as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submited are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) Date

47. Provider ID 48. License Number

49. Address, City, State, Zip Code

50. Phone Number ( ) 51. Treating Provider Specialty

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 subscriber 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:

_____

_____

_____

_____

_____

_____

Mail completed Form to:

Healthplex®
Leadership in Dental Plans

333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608

Members Only Call Customer Service	1- 800-468-0600	Press Option 1
Providers Only Call Provider Hot Line	1- 888-468-2183	Press Option 3

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