For additional dental claim forms,
Please visit our website:
www.jjstanisco.com

Mail completed forms to:
J.J. STANIS AND CO MPANY, INC
377 Oak Street, Suite 406 * Garden City, New York 11530
Phone: 516-465-3900 Fax 516-465-3920

Dental Expense Claim

To Be Completed by Employee

1. Patient First Name / Middle / Last
2. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
3. Sex ☐ Male ☐ Female
4. Married? ☐ Yes ☐ No
5. Patient Date of Birth Mo. / Day / Year
6. For Office Use
7. If Full-Time Student (Age 19 or Over) School / City / State
8. ID Number
9. If Disabled (Age 19 or Over) ☐ Yes ☐ No
10. Name of Group Dental Program: JJ000509
11. Employee First Name / Middle / Last
12. Employee Date of Birth
13. Office Phone (Area Code)
14. Employee Residence Mailing Address
15. City / State / ZIP
16. Are other Family Members Employed? ☐ Yes ☐ No — Name / Social Security / ID Number
17. Date of Birth
18. Name and Address of Employer for item 16
19. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, complete the following:) Dental Plan Name / Group No. / Name and Address of Carrier
20. I Authorize Release of any Information Relating to this Claim.
(Signature of Patient or Signature of Authorized Representative if Minor) Date
If Authorized Representative, Relationship to Minor
21. I Certify that the Above Information is Correct.
Employee Signature Date
22. I Authorize Payment Directly to the Below-Named Dentist.
Employee Signature Date

To Be Completed by Dentist

23. Dentist Name
24. Mailing Address / City / State / ZIP
25. Dentist Phone Number
26. Dentist License Number
27. Dentist SSN or T.I.N.
28. Provider Specialty Code
29. NPI (Treating Dentist)
30. NPI (Billing Entity, if different)
31. First Visit Date Current Series
32. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other
33. Radiographs or Models Enclosed? ☐ Yes ☐ No How Many?
34. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)
35. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)
36. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)
37. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)
38. If Prosthesis, Is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement)
39. Date of Prior Replacement
40. Is Treatment for Orthodontics? ☐ Yes ☐ No — If Services Already Commenced, Enter Date Appliance Placed — Months of Treatment Remaining

Dentist's ☐ Pretreatment Estimate ☐ Statement of Actual Services *(Be sure to sign below)**

41. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)

FACIAL — Lingual — Upper — Lower — Right — Left — Primary — Permanent — FACIAL
INDICATE MISSING TEETH WITH AN "X"

Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo./ Day /Year	ADA Procedure Number	Fee	For Carrier Use Only

42. I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed.
*Signature of Dentist ____ Date Signed ____ Total Fee Actually Charged

43. Address where treatment was performed
Street ____ City ____ State ____ ZIP ____