WellSpan HEALTH
Population Health Services

P.O. Box 2347
York, PA 17405

☐ Dentist's pre-treatment estimate

☐ Dentist's statement of actual services

WellSpan Population Health Dental

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD	3. SEX ☐ M ☐ F	4. PATIENT BIRTHDATE MO DAY YEAR	5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL CITY

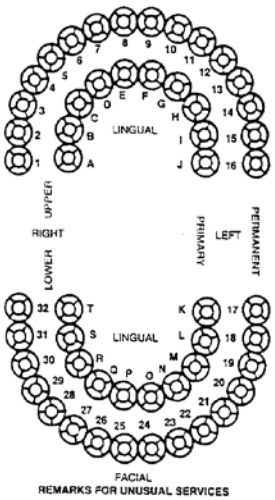
6. EMPLOYEE/ SUBSCRIBER NAME	LAST FIRST MIDDLE INT.		7. EMPLOYEE SOCIAL SECURITY NUMBER
8. EMPLOYEE HOME ADDRESS			9. EMPLOYER (COMPANY) NAME ADDRESS
CITY, STATE ZIP			

10. GROUP NUMBER	IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15	11. EMPLOYEE BIRTH DATE MO DAY YEAR	12. SPOUSE NAME	13. SPOUSE BIRTHDATE MO DAY YEAR
	14. NAME AND ADDRESS OF CARRIER			15. SPOUSE SOCIAL SECURITY #

DENTIST NAME		IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY ☐ NO ☐ YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS		IS TREATMENT RESULT OF AUTO ACCIDENT ☐ NO ☐ YES	
CITY, STATE ZIP		OTHER ACCIDENT ☐ NO ☐ YES	

DENTIST SOC. SEC. NO. OR FED. IDENT. NO.	DENTIST LICENSE	DENTIST PHONE NUMBER	IF PROSTHESIS IS THIS INITIAL PLACEMENT ☐ NO ☐ YES	IF NO, ENTER REASON FOR REPLACEMENT DATE OF PRIOR PLACEMENT
FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT ☐ OFFICE ☐ OTHER	RADIOGRAPHS OR MODELS ENCLOSED ☐ NO ☐ YES HOW MANY?	IS TREATMENT FOR ORTHODONTICS ☐ NO ☐ YES	IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.

TOOTH NO. OR LETTER	SURFACES MOI DLF	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.	DATE SERVICE PERFORMED M D Y	ADA PROCEDURE NUMBER	FEE

RELEASE INFORMATION

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

SIGNED (PATIENT OR PARENT IF MINOR) DATE

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTIST.

SIGNED (PATIENT OR PARENT IF MINOR) DATE

PREDETERMINATION OF COSTS

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT AND I REQUEST PREDETERMINATION OF BENEFITS.

DENTIST SIGNATURE DATE

TREATMENT COMPLETED - PAYMENT REQUESTED

THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGEMENT AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICES. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.

DENTIST SIGNATURE DATE

TOTAL FEE CHARGED	
MAXIMUM ALLOWABLE	
DEDUCTIBLE	
SCP PAYS	
PATIENT PAYS	