J.J. Stanis & Company, Inc. 377 Oak Street – Suite 406 Garden City, NY 11530

For additional dental claim forms, please visit us at our website:

www.jjstanisco.com

DENTAL CLAIM FORM																
1. (CHECK ONE (/)			2. PRIOR AUTHORIZATION NO. PATIENT ID NO.							3. CARRIER NAME AND ADDRESS					
	J DENTIST FEE TREA								Valley Stream Teachers' Association Welfare Fund							
	4. PATIENT NAME	5. RELATIONSHIP TO EMPLOYEE "J SELF J DAUGHTER "J SPOUSE J SON J OTHER				6. SEX -			7. PATI MON		RTH DATE DAY YE		OL CITY			
	9. EMPLOYEE/SUBSCRIBER NAME AND ADDRESS					10. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER				11. EMPLOYEE/SUBSCRIBER BIRTH DATE MONTH DAY YEAR			12. GROUP NUMBER 4904			APLOYER NAME AND ADDRESS
	14. IS PATIENT COVE PLAN? UYES U IS PATIENT COVE UYES UNO	15-A. NAME AND ADDRESS OF OTH				HER CARRIER(S)			15-B. C	BROUP	NUMBER(S	16. OT	HER PLAN-EMPLOYER NAME/ADDRESS			
	17-A.OTHER PLAN - S (IF DIFFERENT I	17-B. OTHER PLAN-SUBSCRIBER ID				DENTIFICATI	18ER			BER BIRTH (DAY YEA		DUSE 'J SON				
19.	I HAVE REVIEWED TH RESPONSIBLE FOR AI ANY INFORMATION RE	ES. I AGE HORIZE I	REE TO BE RELEASE	OF	20. I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTIST ENTITY.											
PATIENT SIGNATURE DATE									SIGNATURE (EMPLOYEE/SI				SCRIBE	R)		DATE
21. NAME OF BILLING DENTIST OR DENTAL ENTITY					Υ					30. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			YES	IF YES, EN	TER DESCR	IPTION AND DATE
	22. ADDRESS WHERE PAYMENT SHOULD BE REMITTED					TED			31. IS TREATMENT RESULT OF AUTO ACCIDENT?			T				
5 5	23. CITY, STATE, ZIP								32. OTHER ACCIDENT?							
温品	24. DENTIST SSN OF	24. DENTIST SSN OR TIN 25. DENTIST LICENSE NO. 26. PHONE NUMBER							33. IF PROSTHESIS, IS IT INITIAL PLACEMENT?					IF NO. REASON FOR REPLACEMENT 34. DATE OF PRIOR PLACEMENT		
羅汀蘇	21. NAME OF BILLING DENTIST OR DENTAL ENTITY 22. ADDRESS WHERE PAYMENT SHOULD BE REMITTED 23. CITY, STATE, ZIP 24. DENTIST SSN OR TIN 25. DENTIST LICENSE NO. 27. 1ST VISIT 28. PLACE OF TX OFF J HOSPITAL J OR MODELS ENCLOSED? DENTIFY MISSING TEETH WITH 'X' 37. EXAMINATION AND TREATME						M	OW ANY?	35. IS TREATMENT FOR ORTHODONTICS?					DATE APPLIANCES PLACED?		MISC. TREATMENT REMAINING?
36.	36. IDENTIFY MISSING TEETH WITH "X" 37. EXAMINATION AND TREATMENT PLAN															FOR ADMINISTRATIVE USE ONLY
	(B) *COO* (B)	2"	тоотн	SURF	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAX				IS. ETC.) DATE OF SE			RVICE YEAR		CEDURE	FEE	
		D'								-						
		Q '														
										-						
	, ලියියුවේ. "ම්යුයුවේ."	92														
38.	REMARKS FOR UNUS	SUAL SERV	ICES													
39.	I HEREBY CERTIFY THE SUBMITTED ARE THE	ACTUAL F	EESTH	AVE CHARG	DICATED BY SED AND INT	END TO	COLLECT	FOR TH	LETED AND HOSE PROCE	THAT TI	HE FEES		41. TOTAL FEE CHARGED 42. PAYMENT BY OTHER PLAN			
10	SIGNED (TREATING DE	NTIST			184		LICE	NSE NU	IMRED	DATE				LLOWABLE		
_	ADDRESS WHERE TR		WAS PE	RFORMED			LIGET	YOU NU	moen	UAT	-		DEDU	CTIBLE		
													CARRIER %			
5	CITY STATE ZIP CODE												PATIENT PAYS			