EBS Benefit Solutions
An Excellus Company

Mail Form to: EBS Benefit Solutions, Inc.
P.O. Box 4863
Syracuse, NY 13221-4863

❑ Pre-Treatment Estimate
❑ Statement of Actual Services

For information please call:
1-800-803-5773 Toll Free
(315) 671-7074

GROUP DENTAL CLAIM FORM

1. Patient Name	2. Relationship to Employee Self ❑ Spouse ❑ Child ❑ Other ❑	3. Sex M ❑ F ❑	4. Patient Birth Date Mo Day Year	5. If Full Time Student - School City

6. Employee / Member / Subscriber Name (First, Middle, Last)	7. Employee Social Sec. #	Employee Birth Date Mo Day Year

8. Employee Mailing Address	9. Company (Employer) Name & Address and/or Division and Plant Location **New York State Teamsters Benefit Funds** **PO Box 4928, 3 Northern Concourse** **Syracuse, NY 13221**

10. Group # **080TPA**	11. Is Spouse or Other Family Member Employed? ❑ Yes ❑ No If yes, Member's Name Social Security #	12. Name and Address of Spouse's or Other Family Member's Employer in Item 11	Spouse Birth Date Mo Day Year

13. Is Patient Covered by Another Dental Plan? Yes ❑ No ❑	If yes, indicate Dental Plan Name	Group #	Name & Address of Carrier

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature.	Signed (Patient or Parent if Minor) ♦	Date
AUTHORIZATION TO PAY BENEFITS TO DENTIST – I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.	Signed (Employee) ♦	Date
CERTIFICATION - I certify that the foregoing information is true and correct.	Signed (Employee) ♦	Date

Any person who knowingly and with intent to defraud any insurance company or other person files a statement 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.

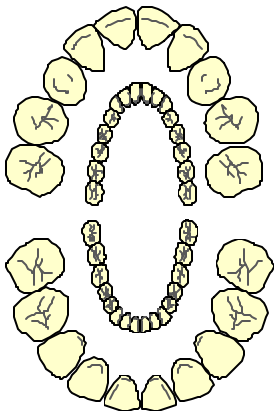
14. Dentist Name	22. Is treatment result of occupational illness or injury? ❑ Yes ❑ No	If yes, enter brief description and dates
15. Mailing Address	23. Is treatment result of auto accident? ❑ Yes ❑ No 24. Other Accident? ❑ Yes ❑ No	

16. Tax I.D. # to be used for tax reporting	Tax I.D. #	Soc. Sec #	25. Are any services covered by another plan? ❑ Yes ❑ No	If yes, name of other plan:

17. Dentist License No.	18. Dentist Phone No.	26. If prosthesis, is this initial placement? ❑ Yes ❑ No	If no, reason for placement:	27. Date of prior placement

19. First Visit Date Current Series	20. Place of Treatment Office/Hosp/ECF/Other	21. Radiographs or Models Encl. Yes ❑ No ❑ If yes, how many?	28. Is treatment for orthodontics? ❑ Yes ❑ No	If services already commenced enter date appliances placed:	Number of months of treatment remaining

Indicate missing teeth with a "X"



29. Examination and Treatment Plan – List in order from tooth No. 1 through tooth No. 32 – Use Charting system shown

Tooth # or Letter	Surface (i.e., M, O, D, B, L..)	Description of Service (incl. X-rays, Prophylaxis, Materials Used, Etc.)	Date of Service Mo Day Year	Procedure # CDT-2/CPT4	Fee

30. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and the fees indicated are those actually charged to the patient regardless of the existence of insurance coverage.	Signed (Dentist) ♦	Date	Total Fee Charged