SELF INSURED SERVICES COMPANY
P.O. BOX 389
DUBUQUE, IA 52004-0389
319-583-7344

DENTAL BENEFIT REQUEST FORM

CHECK ONE:
☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

PATIENT INFORMATION

1. PATIENT NAME FIRST / MIDDLE INITIAL / LAST / SOCIAL SECURITY #	2. RELATIONSHIP TO EMPLOYEE SELF / SPOUSE / CHILD / OTHER	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YEAR	5. IF FULL TIME STUDENT SCHOOL / CITY

6. EMPLOYEE NAME FIRST / MIDDLE INITIAL / LAST	7. EMPLOYEE SOCIAL SECURITY NO.	9. EMPLOYER'S EMPLOYER

8. EMPLOYEE ADDRESS	10. EMPLOYER ADDRESS
CITY STATE ZIP PHONE NO.	

11. GROUP NUMBER	12. LOCATION LOCAL	13. ARE OTHER FAMILY MEMBERS EMPLOYED ☐ YES ☐ NO IF YES, EMPLOYEE NAME / SOC. SEC. NO.	14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN: ☐ YES ☐ NO IF YES GIVE GROUP / NAME / UNION LOCAL / GROUP NO.	NAME AND ADDRESS OF PROVIDER OF BENEFITS

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS REQUEST.	I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST FOR THE SERVICES DESCRIBED BELOW.
► SIGNED PATIENT OR PARENT IF MINOR / DATE	► SIGNED EMPLOYEE OR AUTHORIZED PERSON / DATE

DENTIST'S INFORMATION

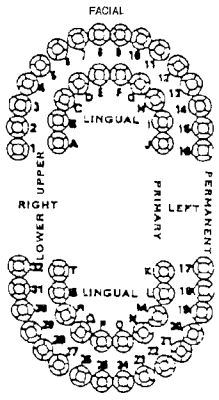
16. DENTIST NAME	17. MAILING ADDRESS	CITY, STATE, ZIP

18. DENTIST SOC. SEC. OR T. I. N.	19. DENTIST LICENSE NO.	20. DENTIST PHONE NO.

21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT OFFICE / HOSP. / ECF / OTHER	23. RADIOGRAPHS OR MODELS ENCLOSED NO / YES / HOW MANY

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY			
25. IS TREATMENT RESULT OF AUTO ACCIDENT			
26. OTHER ACCIDENT			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN			
28. IS PROSTHESIS a. INITIAL PLACEMENT			IF YES, DATE AND TOOTH NUMBER OF MOST RECENT EXTRACTION BEING REPLACED
b. REPLACEMENT			IF YES, REASON FOR REPLACEMENT AND DATE OF PRIOR PLACEMENT
29. IS TREATMENT FOR ORTHODONTICS			IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH X



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

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC. LINE NO.	DATE SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

31. REMARKS FOR UNUSUAL SERVICES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

► SIGNED DENTIST / DATE

TOTAL FEE CHARGED	
Plan Maximum	
Payable Now	
ESTIMATED ADDITIONAL BENEFIT when treatment is completed.*	

*The estimates are based on the information we have at present. Estimates will be subject to eligibility, deductibles and plan maximums and may be reduced by payments made before these services are rendered. Actual payments will be made in the order of claims received.