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

Mail completed forms to:
J.J. STANIS AND COMPANY, 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 (You must review the important statements on page 2 and sign where indicated before completing this section of the form.)

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. EMPLOYEE Social Security / ID Number	9. If Disabled (Age 19 or Over) ☐ Yes ☐ No	10. Name of Group Dental Program		
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.	21. I Certify that the Above Information is Correct.	22. I Authorize Payment Directly to the Below-Named Dentist.
(Signature of Patient or Signature of Authorized Representative if Minor) Date If Authorized Representative, Relationship to Minor	Employee Signature Date	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)**

FACIAL
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
A B C D E F G H I J
Lingual
Upper Lower Right Left Primary Permanent
K L M N O P Q R S T
Lingual
17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
FACIAL
INDICATE MISSING TEETH WITH AN "X"

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

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 ____________