PLEASE MAKE SURE EMPLOYEES MAILING ADDRESS IS LIGIBLE, CURRENT AND CORRECT

New England Dental Administrators, LLC
One Delta Drive
PO Box 2006
Concord, NH 03302-2006
Phone: 800-253-1358

PATIENT SECTION

1. PATIENT NAME (FIRST / MIDDLE / LAST)	2. RELATIONSHIP TO EMPLOYEE (SELF / SPOUSE / CHILD / OTHER)	3. SEX (M / F)	4. PATIENT BIRTHDATE (MO. / DAY / YEAR)	5. IF 19 YEARS OLD AND FULL TIME STUDENT (SCHOOL / CITY)

6. Employee / subscriber name and mailing address	7. Employee / subscriber soc. sec. / ID number	8. Employee / subscriber birthdate (MO. / DAY / YEAR)	9. Employer (company) name and address	10. Group Number

11. Is patient covered by another plan or benefits? Dental ____ Medical ____	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of employer

14-a. Employee / subscriber name (if different than patient's)	14-b. Employee / subscriber soc. sec. number	14-c. Employee / subscriber birthdate (MO. / DAY / YEAR)	15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other ____

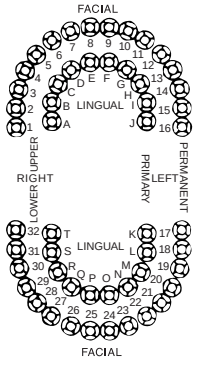
DENTIST SECTION

16. DENTIST NAME	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER DATES
17. MAILING ADDRESS	25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	26. OTHER ACCIDENT			
CITY, STATE, ZIP CODE	27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			

18. DENTIST SOC. SEC. OR TIN #	19. DENTIST STATE LICENSE NO.	20. DENTIST PHONE NO.	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT)	29. DATE OF PRIOR PLACEMENT

21. FIRST VISIT DATE OF CURRENT SERIES	22. PLACE OF TREATMENT (OFFICE / HOSP / ECF / OTHER)	23. RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY	30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER	DATE APPLIANCES PLACED	MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



31. Examination and Treatment Plan - List in Order from Tooth No. 1 through Tooth No. 32 - Use Charting System shown

Tooth # or Letter	Surfaces	Description of Service (including X-rays, Prophylaxis, materials used, etc.) LINE NO.	Start Date if Multiple Appointment Procedure (MO. / DAY / YEAR)	Completion Date (MO. / DAY / YEAR)			Procedure Number	Fee			POLICY	POLICY
		1										
		2										
		3										
		4										
		5										
		6										
		7										
		8										
		9										
		10										
		11										
		12										
		13										
		14										
		15										

CONSULTANT ____
PROF. REL ____
PRE-EDIT ____
DATA ENTRY ____
ELIGIBILITY ____
PERIODONTIC ____

PLEASE INDICATE TOTAL FEE CHARGED

★PREDETERMINATION OF COSTS:
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT AND I REQUEST PREDETERMINATION ON THESE SERVICES IN ACCORDANCE WITH PLAN RULES AND REGULATIONS.

36. PRE-TREATMENT RADIOGRAPHS REQUIRED FOR DENTAL CONSULTANT'S REVIEW.

37. FEE BREAKDOWN REQUIRED BY PROCEDURE CODE.

38. CHARTING REQUIRED FOR DENTAL CONSULTANT'S REVIEW.

IF MORE THAN 15 PROCEDURES ARE PERFORMED OR PLANNED, PLEASE COMPLETE ANOTHER ATTENDING DENTIST'S STATEMENT. ADS (99)

33. DENTIST SIGNATURE ____ DATE ____

34. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Signed (Patient) ____ Date ____

35. I hereby authorize payment of the dental benefits otherwise payable to me directly to the dentist indicated above.

Signed (Employee / subscriber) ____ Date ____

MAXIMUM APPROVED	
AMOUNT APPLIED TO DEDUCTIBLE	
PLAN PAYS	
PATIENT PAYS	

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38

MARKED NUMBER ABOVE (1-38) REFER TO MISSING DATA NEEDED TO PROCESS CLAIM.

NEDA

REV. 7/99