AIG AMERICAN GENERAL

# Attending Dentist's Statement

The United States Life Insurance Company in the City of New York
Member of American International Group, Inc.

**PATIENT SECTION**

**Check One:**
☐ **Dentist's pre-treatment estimate**
☐ **Dentist's statement of actual services**

**Return Claim to:**
The United States Life Insurance Company in the City of New York
P O Box 1581
Neptune, NJ 07754-1581

| 1. Patient name First / M.I. / Last | 2. Relationship to Employee ☐ self ☐ child ☐ spouse ☐ other_____ | 3. Sex M F | 4. Patient birthdate MO DAY YR | 5. If full-time student School / City |
|---|---|---|---|---|

| 6. Employee/Subscriber name and mailing address | 7. Employee/Subscriber soc. sec. number | 8. Employee/Subscriber birthdate MM DD YYYY | 9. Employer (Company) Name and Address | 10. Group Number |
|---|---|---|---|---|

| 11. Is Patient covered by another plan of 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 YR | 15. Relationship to Patient ☐ self ☐ child ☐ spouse ☐ other_____ |
|---|---|---|---|

**I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.**

▶ _____ Signed (Patient, or parent if minor) _____ Date

**I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.**

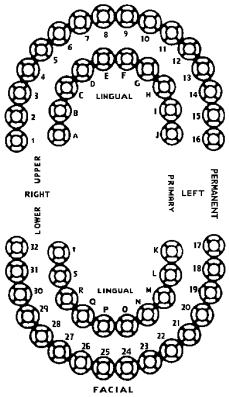
▶ _____ Signed (Insured person) _____ Date

## DENTIST SECTION

| | | | | | | |
|---|---|---|---|---|---|---|
| 16. Dentist Name | 24. Is treatment result of occupational illness or or injury? | No | Yes | If Yes, enter brief description and dates. | | |
| 17. Mailing Address | 25. Is treatment result of auto accident? | | | | | |
| | 26. Other accident? | | | | | |
| City, State, Zip | 27. Are any services covered by another plan? | | | | | |
| 18. Dentist Soc. Sec. or T.I.N. / 19. Dentist 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 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"

FACIAL




32. Remarks for unusual services

31. 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 |
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**I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures**

▶ _____ Signed (Dentist) Date: _____

| | |
|---|---|
| **Total Fee Charged** | |
| Max. Allowable | |
| Deductible | |
| Carrier # | |
| Carrier pays | |
| Patient pays | |