COMPLETED FORM TO BE RETURNED TO:
GEMGroup
BRANDYWINE CORPORATE CENTER
SUITE 303
650 NAAMANS RD.
CLAYMONT, DE 19703

TELEPHONE NUMBERS:
302-798-6801
800-223-7405

GROUP DENTAL PROGRAM

(A) TO BE COMPLETED BY EMPLOYEE

BY

PATIENT NAME | RELATIONSHIP TO EMPLOYEE: SELF, SPOUSE, CHILD, OTHER | SEX: M, F | PATIENT BIRTHDATE: MO, DAY, YR

EMPLOYEE NAME FIRST, MIDDLE, LAST | IF FULL TIME STUDENT, SCHOOL

EMPLOYEE MAILING ADDRESS | EMPLOYEE TELEPHONE NO. | EMPLOYEE SOCIAL SECURITY NO.

CITY, STATE, ZIP | EMPLOYEE BIRTHDATE | UNION NAME AND LOCAL NUMBER

ARE OTHER FAMILY MEMBERS EMPLOYED? YES ☐ NO ☐ "IF YES", NAME AND ADDRESS OF EMPLOYER

IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES ☐ NO ☐ "IF YES" | DENTAL PLAN NAME | UNION LOCAL | GROUP NO. | NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT OR PARENT IF MINOR) | DATE

(B) ATTENDING DENTIST'S STATEMENT

		NO	YES	
DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT?			
	OTHER ACCIDENT?			
CITY, STATE, ZIP	ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
FEDERAL ID NO., IF NONE, SOCIAL SECURITY NO. / DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) / DATE OF PRIOR PLACEMENT
FIRST VISIT DATE CURRENT SERIES / PLACE OF TREATMENT: OFFICE, HOSP, ECF, OTHER / RADIOGRAPHS OR MODELS ENCLOSED? NO, YES, HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

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

IDENTIFY MISSING TEETH WITH "X"

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
RIGHT
LEFT
PRIMARY
PERMANENT
LOWER
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
T S R Q P O N M L K
LINGUAL
FACIAL

REMARKS FOR UNUSUAL SERVICES

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

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE	FOR BENEFIT FUND USE ONLY

***PREDETERMINATION OF COSTS**
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST PREDETERMINATION OF BENEFITS.

DENTIST SIGNATURE | DATE

****TREATMENT COMPLETED-PAYMENT REQUESTED**
THE TREATMENT LISTED WAS COMPLETED AND WAS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST PAYMENT.

DENTIST SIGNATURE | DATE

***FOLLOWING BENEFIT DETERMINATION I HAVE REVIEWED THE ATTENDING DENTIST'S STATEMENT, I AGREE TO BE RESPONSIBLE FOR SERVICES NOT COVERED BY THE DENTAL PLAN.

AUTHORIZATION TO PAY BENEFITS TO DENTIST

INSURED SIGNATURE | DATE

TOTAL FEE CHARGED	
PAID TO DENTIST	
PAID TO INSURED	