Fidelio INSURANCE COMPANY

2826 MT. CARMEL AVENUE
GLENSIDE, PA 19038
215-885-2443 / Fax 215-576-5849
1-800-262-4949

International Union of Operating Engineers of Eastern PA & DE

ATTENDING DENTIST'S STATEMENT

SIGN BELOW FOR PREDETERMINATION OR PAYMENT

STAPLE X-RAYS TO FORM

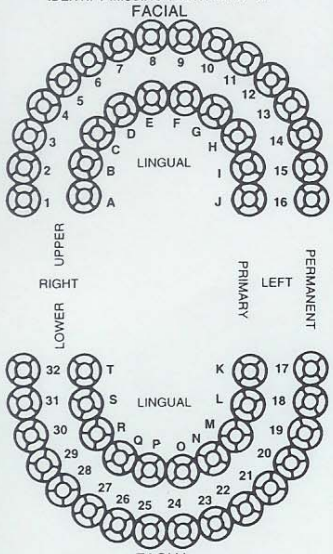
EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE — SELF | SPOUSE | CHILD | OTHER
3. SEX — M | F
4. IMPORTANT PATIENT BIRTHDATE — MO. | DAY | YEAR
5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL / CITY
6. EMPLOYEE SUBSCRIBER NAME — LAST / FIRST / MIDDLE INITIAL
7. IMPORTANT EMPLOYEE SOCIAL SECURITY NUMBER
8. EMPLOYEE HOME ADDRESS
CITY, STATE ZIP
9. EMPLOYER (COMPANY) NAME AND ADDRESS
I.U.O.E. of EASTERN PA & DE BENEFIT FUNDS
10. GROUP NUMBER
IF PATIENT COVERED BY ANOTHER DENTAL PLAN, COMPLETE ITEMS 11 THROUGH 15.
11. FIDELIO COVERED EMPLOYEE BIRTHDATE — MO. | DAY | YEAR
12. SPOUSE NAME
13. SPOUSE BIRTHDATE — MO. | DAY | YEAR
14. NAME AND ADDRESS OF CARRIER
15. SPOUSE SOCIAL SECURITY NUMBER

DENTIST NAME
MAILING ADDRESS
CITY, STATE ZIP
DENTIST SOC. SEC. NO. OR FED. IDENT. NO.
DENTIST LICENSE
DENTIST PHONE NO.
FIRST VISIT DATE CURRENT SERIES
PLACE OF TREATMENT — OFFICE | OTHER
RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐
HOW MANY?

IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO ☐ YES ☐
IS TREATMENT RESULT OF AUTO ACCIDENT? NO ☐ YES ☐
OTHER ACCIDENT? NO ☐ YES ☐
IF YES, ENTER BRIEF DESCRIPTION AND DATES
IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO ☐ YES ☐
IF NO, ENTER REASON FOR REPLACEMENT
DATE OF PRIOR PLACEMENT
IS TREATMENT FOR ORTHODONTICS? NO ☐ YES ☐
IF SERVICES ALREADY COMMENCED, ENTER:
DATE APPLIANCES PLACED
MONTHS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

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

TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Service Including X-rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO. DAY YEAR		ADA PROCEDURE NUMBER	FEE

* **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 ABOVE WAS COMPLETED, NECESSARY IN MY PROFES-

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT.

PATIENT

TOTAL FEE CHARGED	
PATIENT PAYS	
FIDELIO PAYS	

FORM FID/PA-0101-97

47