I-60

MAY BE DUPLICATED

STATE OF NEW YORK
OFFICE OF VICTIM SERVICES
AE Smith State Office Building,
80 South Swan Street, 2nd floor
ALBANY, NEW YORK 12210-8002

CLAIM NO.	

DENTAL CLAIM FORM

TO BE COMPLETED BY ATTENDING DENTIST

I.

1. Name of victim:	2. Date of crime:
3. Victim's Home Mailing Address:	4. Have you made application for services to Medicaid, Workers' Compensation, or any other insurance plan in relation to this injury? If yes, which one? ☐ Yes ☐ No
5. What history of crime related injury did the victim give you?	
6. What is your diagnosis (include results of x-rays)?	
7. What is your prognosis?	
8. Do you believe this dental work is related to the crime as described in box 5? Please explain. ☐ Yes ☐ No	

II.

1. Dentist Name:	2. If Prosthesis and/or Crown, is this initial placement? ☐ Yes ☐ No	(If No, Reason for Replacement)	Date of Prior Placement
3. Mailing Address:	4. Is this Treatment for Orthodontics? ☐ Yes ☐ No	If Services Already Commenced, Enter:	Date Appliance Placed: / Mos. Treatment Remaining
5. City, State, Zip Code			
6. Dentist Tax Identification No.:	7. Dentist License No.:	8. I am a Specialist in: ☐ Orthodontics ☐ Endodontics	☐ Oral Surgery ☐ Periodontics ☐ Other

9. Date of First examination	Place of Treatment Office, Hosp. Or Other	Radiographic or Model Enclosed? NO	YES	HOW MANY?

10. Check Only One:

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES: I hereby certify that the procedures below were rendered and completed on the dates indicated.

☐ DENTIST'S TREATMENT PLAN (PRE-DETERMINATION OF BENEFITS).

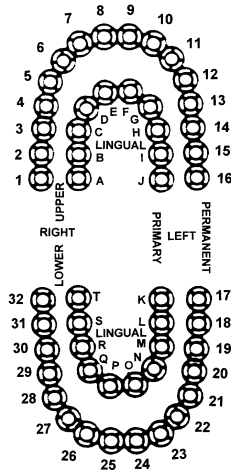
_____ _____
SIGNED (DENTIST) DATE

11. Was condition related to victim's employment? ☐ Yes ☐ No
Was condition related to an Auto Accident? ☐ Yes ☐ No
Was condition related to Other Accident? ☐ Yes ☐ No

12. What permanent effects, if any, do you anticipate?

13. Examination and Treatment Plan. List in Order from Tooth No. 1 through Tooth No. 32

IDENTIFY MISSING TEETH WITH "X"



Tooth # or Letter	Surface	DATE SERVICE PERFORMED Mo	Day	Year	ADA Procedure Code	Fee	Description of Service (Including x-rays, prophylaxis, materials used, etc.)	Crime Related Y or N
					TOTAL FEE CHARGED			