BENEFIT TRUST FUND

Phone: (845) 562-7988 • 52 Piercees Road Newburgh NY 12550

Proposed Orthodontic Treatment

Date _____ Member# _____ Patient _____

- ☐ Upper and lower metal braces
- ☐ Upper clear and lower clear metal braces
- ☐ Upper and lower clear braces
- ☐ Upper and lower Invisalign
- ☐ Invisalign upper
- ☐ Invisalign lower
- ☐ Upper and lower Invisalign Express
- ☐ Upper Invisalign Express
- ☐ Lower Invisalign Express
- ☐ Upper metal braces
- ☐ Upper clear braces
- ☐ Lower metal braces
- ☐ Lower clear braces
- ☐ Stage I treatment

Dr.'s Name: _____

Dr.'s Address _____

$ _____ 1. Diagnostic Records:

$ _____ 2. Treatment Fee:

$ _____ 3. Retention Fee:

$ _____ 4. Subtotal:

$ _____ 5. Add charge for clear braces: ☐ ☐ ☐ (Upper / Lower / Both)

$ _____ 6. Total Fee:

$ _____ 7. Insurance Benefit (if another plan is involved (Attach copy of primary EOB if applicable)

Important Reminder:

For comprehensive Ortho cases, procedure date is date full banding is completed.

*Doctor's Signature _____

*Member Signature _____