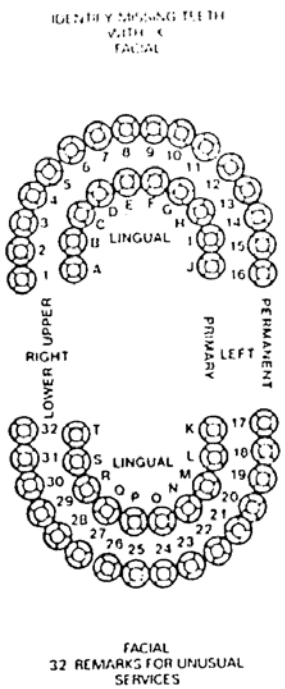
DESCRIPTION OF SERVICES



Tooth No.	Surface	Description (including X-rays, materials used, prophylaxis, etc.)	Date of Service	Fee	Union Use

FOR UNION USE ONLY	Am't Reimbursed $ _____ Date _____ Member _____ Dependant _____ Total to Date $ _____ Approver's initials_____