

DENTAL CLAIM FORM

CHECK ONE:

Pretreatment estimate (please submit radiographs/models)

Statement of actual service

PATIENT COVERAGE INFORMATION	1. Patient name (first, middle, last)		2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		4. Patient's birthdate		5. Employee I.D.#			
	6. Employee name and mailing address									7. Group number		
	8. Is patient covered by another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete 8-12 Is patient covered by a medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			9. Name and address of other dental plan carriers.								
	10. Employee/name of other plan (if different than patient's)				11. Employee social security or I.D. #				12. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> Other			

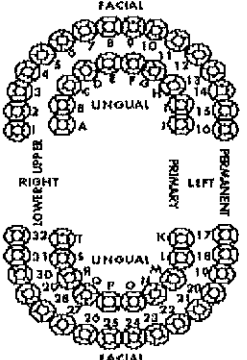
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Signed (Patient or parent if minor) _____ Date _____

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BILLING DENTIST	13. Name of billing dentist or dental entity				21. Is treatment result of occupational illness? Or injury? No Yes		If yes, enter brief description and dates				
	14. Address where payments should be remitted				22. Is treatment result of auto accident? No Yes						
	City, State, Zip				23. Other accident? No Yes						
	15. Dentist Soc. Security # or T.I.N.		16. Dentist License #		17. Dentist phone #		24. If prosthesis, is this initial placement? No Yes		(if no, reason for replacement)		28. Date of prior placement
	18. First visit date, current series		19. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other		20. Radiographs or models enclosed? <input type="checkbox"/> No <input type="checkbox"/> Yes How many? _____		25. Is treatment for orthodontics? No Yes		If services already commenced enter:	Date appliances placed	Months treatment remaining

Identify missing teeth with "X" 	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date of service performed MO DAY YR	Procedure Number	Fee	FOR ADMINISTRATIVE USE ONLY	

27. Remarks for unusual services

I hereby certify that the procedure(s) as indicated by date have been completed and that the fee(s) submitted are the actual fee(s). I have charged and intend to collect for those procedures.

Signed (treating dentist) _____ Date _____

	TOTAL FEE CHARGED		
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