

DENTAL BENEFITS CLAIM

CHECK ONE:
 DENTIST'S PRE-TREATMENT ESTIMATE
 DENTIST'S STATEMENT OF ACTUAL SERVICES

EMPLOYEE MUST COMPLETE TOP SECTION EVEN IF DENTIST USES OWN CLAIM FORM.

PATIENT NAME _____ EMPLOYEE NAME First Middle Last _____ EMPLOYEE MAILING ADDRESS _____ CITY, STATE, ZIP _____ IS ANY DEPENDENT UNDER THIS PLAN EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU OR YOUR COVERED DEPENDENTS HAVE OTHER GROUP HEALTH COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE IDENTIFY: <input type="checkbox"/> SPOUSE <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> CHILD. NAME _____ DATE OF BIRTH _____ OTHER HEALTH COVERAGE _____ SOC. SEC. NO. OF PERSON WITH OTHER COVERAGE _____ POLICY NO./ I.D. NO. _____ NAME _____ [] [] [] - [] [] [] - [] [] [] [] EFF. DATE _____ ADDRESS _____ DOES OTHER GROUP COVERAGE LISTED ABOVE HAVE DENTAL BENEFITS <input type="checkbox"/> YES <input type="checkbox"/> NO	Relationship to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other <input type="checkbox"/> M <input type="checkbox"/> F Patient Birthdate Mo. - Day - Year _____ Full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No EMPLOYEE'S SOCIAL SECURITY NUMBER MUST BE PROVIDED [] [] [] - [] [] [] - [] [] [] [] I hereby authorize release of any information related to this claim. If the claim is for a dependent, the dependent meets the eligibility requirements as outlined in the Summary Plan Description. I hereby authorize payment directly to the below named dentist of the group benefits otherwise payable to me. Signed (patient, or parent if minor) _____ Date _____ Signed (employee) _____ Date _____
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ATTENDING DENTIST'S STATEMENT X-RAYS OR STUDY MODELS TO BE SUBMITTED UPON REQUEST ONLY

1. DENTIST'S NAME _____	6. Is treatment result of occupational injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If accident, enter brief description and dates.
2. MAILING ADDRESS _____ NEW ADDRESS? <input type="checkbox"/> YES	7. Other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
STREET _____	8. Are any services covered by another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
CITY _____ STATE _____ ZIP _____	9. If yes, plan name? _____	10A. If no, reason for replacement and Date of prior placement _____
3. Enter the TAXPAYER IDENTIFYING NUMBER to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.	10. If prosthesis is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. DENTIST PHONE NO. _____	5. FIRST VISIT DATE CURRENT SERVICE _____	11. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If services already commenced, enter dates appliances placed, months treatment remaining.

ADMINISTRATIVE USE ONLY		12. Examination and treatment plan. List in order from tooth no. 1 through tooth no. 32 - Use charting system shown																																																																																				
		<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;">Tooth # or Letter</th> <th style="width:10%;">Surface</th> <th style="width:40%;">Description of Service (Including x-rays, prophylaxis, materials used., etc.)</th> <th style="width:10%;">Date Service Performed Mo. Day Year</th> <th style="width:10%;">Procedure Number</th> <th style="width:10%;">Fee</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>7</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>8</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>9</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>10</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>11</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>12</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>13</td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>	Tooth # or Letter	Surface	Description of Service (Including x-rays, prophylaxis, materials used., etc.)	Date Service Performed Mo. Day Year	Procedure Number	Fee	1						2						3						4						5						6						7						8						9						10						11						12						13					
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I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE FEES I USUALLY CHARGE AND ACCEPT FOR SUCH PROCEDURES.

TOTAL FEE CHARGED _____

SIGNED (DENTIST) _____ DATE _____