



GROUP DENTAL PLAN CLAIM FORM

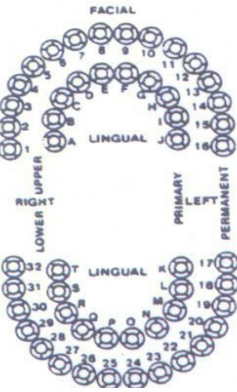
GROUP NO.

EMPLOYEE AND PATIENT

1. PATIENT NAME		RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD			3. SEX M F		4. PATIENT BIRTHDATE MO. DAY YEAR			5. PATIENT'S SSN or ID NUMBER	
6. EMPLOYEE NAME FIRST MIDDLE LAST				7. EMPLOYEE SOCIAL SECURITY NO.				8. EMPLOYEE'S EMPLOYER			
9. EMPLOYEE HOME ADDRESS STREET						CITY			STATE ZIP		
10. GROUP NUMBER		11. IS PATIENT EMPLOYED? NO <input type="checkbox"/> YES <input type="checkbox"/> IF			12. NAME AND ADDRESS OF EMPLOYER						
13. IS PATIENT COVERED BY ANOTHER HEALTH PLAN? NO <input type="checkbox"/> YES <input type="checkbox"/> IF		DENTAL PLAN NAME			14. GROUP NO.		15. NAME AND ADDRESS OF CARRIER				

DENTIST INFORMATION

I authorize my attending dentist to release any information relating to the claim.					
Patient's Signature (Parent if patient is a minor) _____ Date _____					
16. DENTIST NAME FIRST MIDDLE LAST				24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	
17. MAILING ADDRESS STREET				25. IS TREATMENT RESULT OF AUTO ACCIDENT?	
CITY STATE ZIP				26. OTHER ACCIDENT?	
18. DENTIST SOC. SEC OR TIN				27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	
19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	
21. FIRST VISIT DATE CURRENT SERIES		22. PLACE OF TREATMENT OFFICE HOSP ECF OTHER		29. DATE OF PRIOR PLACEMENT	
23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?		30. IS TREATMENT FOR ORTHODONTICS?		IF NO, REASON FOR REPLACEMENT	
				IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED	
				MOS. TREATMENT REMAINING	

DENTIST – CHECK ONE <input type="checkbox"/> PRETREATMENT ESTIMATE <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES IDENTIFY MISSING TEETH WITH "X" 	31. EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 – USING CHARTING SYSTEM SHOWN								ADMINISTRATIVE USE ONLY			
	Tooth No. or Ltr.	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Date Service Performed			Procedure Number	Fee		Prevent	Basic	Major
				Mo.	Day	Yr.						
32. REMARKS FOR UNUSUAL SERVICES												

TO BE COMPLETED BY EMPLOYEE				IMPORTANT – READ CAREFULLY				TOTAL FEE CHARGED			
CERTIFICATION: I hereby certify that I have reviewed the plan of treatment and the fees to be charged and I also certify to questions 1 through 13.											
EMPLOYEE'S SIGNATURE: _____						DATE: _____					
ASSIGNMENT: I hereby assign benefits payable to the attending dentist.											
EMPLOYEE'S SIGNATURE: _____						DATE: _____					
TO BE COMPLETED BY DENTIST											
I hereby certify that the services listed above have been performed on the above-named patient on the dates indicated:											
DENTIST'S SIGNATURE: _____						DATE: _____					
				If Applicable		Deductible					
						Percent Payable					
						Amount Payable					
These insurance benefits will, subject to policy provisions, be payable if the described procedures are performed during a period of the patient's eligibility.											
(The patient's personal eligibility has not been verified at the time of predetermination.)											

INSURANCE PAYS	▶
PATIENT PAYS	▶

