

Dental Claim Form

Check one:
 Dentist's pre-treatment estimate
 Dentist's statement of actual services

PATIENT COVERAGE INFORMATION	1. Patient Name first m.i. last	2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other	3. Sex m f	4. Patient birthdate MM DD YYYY	5. If full time student school city	
	6. Employee/subscriber name and mailing address	7. Employee/subscriber soc. sec. or I.D. number	8. Employee/subscriber birthdate MM DD YYYY	9. Employer (company) name and address	10. Group number	
	11. Is patient covered by another dental plan? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, complete 12-a. Is patient covered by a medical plan? <input type="checkbox"/> yes <input type="checkbox"/> no	12-a. Name and address of carrier(s)	12-b. Group no (s)	13. Name and address of other employer(s)		
	14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. or I.D. number	14-c. Employee/subscriber birthdate MM DD YYYY	15. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other		

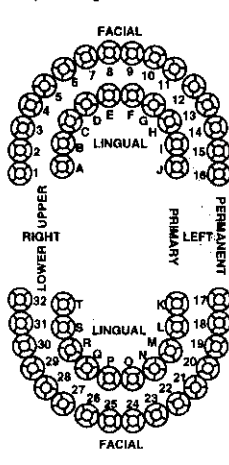
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

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 _____ Signed (Insured person) _____ Date _____

BILLING DENTIST	16. Name of Billing Dentist or Dental Entity	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates					
	17. Address where payment should be remitted City, State, Zip	25. Is treatment result of auto accident?								
	18. Dentist Soc. Sec. or T.I.N.	19. Dentist license no.	20. Dentist phone no.	27. If prosthesis, is this initial placement?	(If no, reason for replacement)	28. Date of prior placement				
	21. First visit date current series	22. Place of treatment Office Hosp. ECF Other	23. Radiographs or models enclosed?	No	Yes	How many?	29. Is treatment for orthodontics?	If services already commenced enter:	Date appliances placed	Mos. treatment remaining

Identify missing teeth with "x"



30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date of service performed Mo. Day Year	Procedure number	Fee	For administrative use only

31. Remarks for unusual services

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

Signed (Treating Dentist) _____ License Number _____ Date _____	Total Fee Charged
	Max. Allowable
	Deductible
	Carrier %
	Carrier pays
	Patient pays