


DENTAL CLAIM FORM

PART 1 – DENTIST	UNIQUE NO. _____ SPEC. _____ PATIENT'S OFFICE ACCOUNT NO. _____	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND THORIZE PAYMENT DIRECTLY OT HIM/HER
P A T I E N T PHONE NO. _____	D E N T I S T PHONE NO. _____	_____ SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION DPLICATE FORM <input type="checkbox"/>	I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ _____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST AND THE PLAN MEMBER. _____ SIGNATURE OF PATIENT (PARENT/GUARDIAN)
OFFICE VERIFICATION/DENTIST'S SIGNATURE	

DATE OF SERVICE							PROCEDURE CODE	INT'L TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	FOR CARRIER USE			
DAY	MO.	YR	ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE										
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & O.E.												TOTAL FEE SUBMITTED		CLAIM NO.		

PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER

1. GROUP POLICY / PLAN NO. _____ DIVISION / SECTION NO. _____
 EMPLOYER _____
 NAME OF INSURING AGENCY OR PLAN _____

2. YOUR NAME (PLEASE PRINT) _____
 YOUR CERTIFICATE NO. _____
 OR S.I.N. OR I.D. NO. _____
 YOUR DATE OF BIRTH _____ DAY MONTH YEAR
 YOUR EMAIL ADDRESS _____

3. DO YOU WANT ANY UNPAID BALANACE FROM THIS CLAIM REIMBURSED FROM YOUR HEALTH SERVICE SPENDING ACCOUNT (IF ELIGIBLE)? YES NO

PART 3 – PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER / SUBSCRIBER _____
 DATE OF BIRTH _____ DAY MONTH YEAR
 IF CHILD, INDICATE STUDENT HANDICAPPED
 IF STUDENT, INDICATE SCHOOL _____
 PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHE GROUP INSURANCE OR DENTAL PLAN, W/C.B. OR GOV'T PLAN? NO YES
 POLICY NO. _____ SPOUSE DATE OF BIRTH _____
 NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS NO YES
 4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT NO YES
 5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO YES
 6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE
 DATE _____ DAY MONTH YEAR

 SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER

PART 4 – POLICY HOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE, SEE ABOVE*)

	DAY	MONTH	YEAR	CONTRACT HOLDER	DAY	MONTH	YEAR	AUTHORIZED SIGNATURE
1. DATE COVERAGE COMMENCED								
2. DATE DEPENDENT COVERED								
3. DATE TERMINATED								

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL. UNLESS ASSIGNED, BENEFITS ARE PAYABLE TO THE PLAN MEMBER.
 *** NOTE: DO NOT STAPLE OR TAPE RECEIPTS TO THE CLAIM FORM ***