

## Dental Claim Form

### To Be Completed by Employee

1. Patient First Name Middle Last			2. Relationship to Employee <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other		3. Sex <input type="radio"/> Male <input type="radio"/> Female	4. Married? <input type="radio"/> Yes <input type="radio"/> No
5. EMPLOYEE Social Security / ID Number			6. Patient Date of Birth Mo. / Day / Year		7. Name of Group	
8. Employee First Name Middle Last			9. Employee Date of Birth	10. Office Phone (Area Code)		
11. Employee Residence Mailing Address				12. City, State, Zip		
13. Are other Family Members Employed? <input type="radio"/> Yes <input type="radio"/> No Name Social Security / ID Number		14. Date of Birth	15. Name and Address of Employer for Item 16			
16. Is Patient Covered by Another Dental Plan? <input type="radio"/> Yes <input type="radio"/> No (If Yes, complete the following:) Dental Plan Name Group No. Name and Address of Carrier						
17. I Authorize Release of any Information Relating to this Claim  (Signature of Patient or Signature of Authorized Representative if Minor) Date  If Authorized Representative, Relationship to Minor		18. I Certify that the Above Information is Correct.  Employee Signature Date		19. I Authorize Payment Directly to the Below Named Dentist.  Employee Signature Date		

### To Be Completed by Dentist

20. Dentist Name		21. Mailing Address City State Zip	
22. Dentist Social Security Number or T.I.N.		23. Dentist License Number	24. Dentist Phone Number
25. First Visit Date Current Series	26. Place of Treatment <input type="radio"/> Office <input type="radio"/> Hospital <input type="radio"/> ECF <input type="radio"/> Other _____		27. Radiographs or Models Enclosed? <input type="radio"/> Yes <input type="radio"/> No How Many? _____
28. Is Treatment Result of Occupational Illness or Injury? <input type="radio"/> Yes <input type="radio"/> No (If Yes, Enter Brief Description and Dates)		29. Is Treatment Result of Auto Accident? <input type="radio"/> Yes <input type="radio"/> No (If Yes, Enter Brief Description and Dates)	
30. Other Accident? <input type="radio"/> Yes <input type="radio"/> No (If Yes, Enter Brief Description and Dates)		31. Are any Services Covered by Another Plan? <input type="radio"/> Yes <input type="radio"/> No (If Yes, Enter Brief Description and Dates)	
32. If Prosthesis, is this Initial Placement? <input type="radio"/> Yes <input type="radio"/> No (If No, Reason for Replacement)			33. Date of Prior Replacement?
34. Is Treatment for Orthodontics? <input type="radio"/> Yes <input type="radio"/> No	If Services Already Commenced, Enter Date Appliance Placed		Months of Treatment Remaining

### Dentist's — Pretreatment Estimate Statement of Actual Services (Please sign below)\*

	38. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)						
	Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo. / Day / Year	ADA Procedure Number	Fee	For Carrier Use Only

35. I Herby Certify That The Services Listed Above <input type="radio"/> Will Be <input type="radio"/> Have Been Performed			Total Fee	
* Signature of Dentist _____ Date _____			Actually Charged	
36. Address where treatment was performed				
Street _____	City _____	State _____	Zip _____	