DENTAL CLAIM FORM

TO BE COMPLETED BY EMPLOYEE – USE BLACK INK ONLY

1. Employer's Name			2. Policy/Group #
3. Employee's ID	4. Employee's Name		5. Employee's Birthdate (MM/DD/YYYY)
6. Active ☐ Retired ☐ Date Retired	7. Employee's Full Address New Address?		8. Employee's Daytime Phone
9. Patient's Name	10. Patient's ID #	11. Patient's Birthdate	12. Patient's Relationship to Employee (Self, Spouse, Child, Other) Self
13. Patient's Address (if different from Employee)	14. Patient's Sex Male ☐ Female ☐	15. Full-time Student Yes ☐ No ☐	16. Graduating Date 17. School/City
18. Marital Status Married ☐ Single ☐	19. Is Patient Employed? No ☐ Yes ☐		20. Employer Name & Address
21. Is claim related to an accident? No ☐ Yes ☐ Date	Time		22. Is claim related to employment? No ☐ Yes ☐

23. Are any family members' expenses covered by another group health plan, group pre-payment plan (BCBS, etc.), no-fault auto insurance, Medicare or any federal, state, or local government plan? No ☐ Yes ☐

24. If yes, provide policy/contract holder name, policy number, and name/address of Company/administrator

25. Member's ID #	26. Member's Name	27. Member's Birthdate

28. I authorize payment of dental benefits to the dentist or supplier of service.

Patient/Authorized Person Signature *Date*

TO BE COMPLETED BY DENTIST – USE BLACK INK ONLY

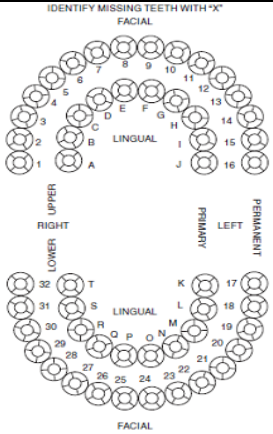
30. This a request for: ☐ Services Rendered ☐ Pre-Treatment Estimate Predetermination/Preauthorization #

31. Dentist's Name & Full Address	32. NPN #	33. License #	34. Phone ( )
	35. Taxpayer ID for 1099 Reporting (required by law)		
	36. First Visit Date Current Series		37. Place of Treatment (Office, Hospital, ECF, Other)
	38. Radiographs or models enclosed? No ☐ Yes ☐	How Many?	Office

Is treatment the result of	No	Yes	If yes, enter brief description and dates	
39. Occupational illness or injury				
40. Auto accident				
41. Other accident				
42. Are any services covered by another plan?				
43. If prosthesis, is this initial placement?			If no, date of prior placement/reason for replacement	
44. Is treatment for orthodontics?			Date appliance placed	Initial Appliance Fee
			No. months of treatment	Monthly Fee
			No. months remaining	Total Case Fee

45. To expedite claim handling, identify all missing teeth with 'X'.

46. Examination/treatment plan. List in order, tooth # 1 - 32.



Tooth #/ Letter	Date Previously Extracted	Surface	Description of Service (xray, prophylaxis, materials)	Date Service Performed	Procedure #	Fee

47. 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 this patient and intend to accept for those procedures.

Dentist's Signature *Date*

48. NPN #

Total charge $

Amount paid $

Balance due $

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