



STANDARD DENTAL CLAIM FORM

PART 1 DENTIST	UNIQUE NO.	SPEC.	PATIENTS OFFICE ACCOUNT NO.		I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER		
P A T I E N T	D E N T I S PHONE NO.				X	NATURE OF S	UBSCRIBER)
FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATIONS.			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. X SIGNATURE OF PATIENT (PARENT/GUARDIAN)				
			OFFICE VERIFICATION				
DATE OF SERVICE PRO- INTL. DAY MO. YR. CEDURE TOOTH TOOTH CODE CODE SURFACES	DENTIST'S LABORATI	ORY	TOTAL CHARGES FOR CARRIER USE				
		-		ALLOWED A	MOUNT INC	%	PATIENT'S SHARE
				CHEQUE NO.		DATE	
				DEDUCTIBL	E PATIEN	T PAYS	PLAN PAYS
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.	TOTAL FEE SUBMITTED			CLAIM NO.			
INSTRUCTIONS FOR CLAIM SUBMISSION BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER. IF YOU PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE. *IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.							
PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER							
			YOUR NAME (PLEASE PRINT)				
			UR CERT. NO. OR S.I.N. OR I.D. NO UR DATE OF BIRTH				
PART 3 - PATIENT INFORMATION							
1. PATIENT: RELATIONSHIP TO EMPLOYEE/ 3. IS			ANY TREATMENT REQUIRED YES, GIVE DATE AND DETAIL		AN ACCIDENT?	□ NO [YES
DATE OF BIRTH IF CHILD INDICATE: STUDENT HANDICAPPED 4.			IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. — YES				
			IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? IN NO IN YES I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO				
тн			HE INSURER / PLAN ADMINIS	TRATOR AND CERTIF			
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTH PLAN, W.C.B. OR GOV'T PLAN?	IER GROUP INSURACE OR DENTAL	C	OMPLETE TO THE BEST OF M	Y KNOWLEDGE.			
	тн	х			ı	DAY DAY	MONTH YEAR
NAME OF OTHER INSURING AGENCY OR PLAN SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER							
PART 4 POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)							
1. DATE COVERAGE COMMENCED 2. DATE DEPENDENT COVERED	4. CONTRACT HOLDER		DATE MONTH YEAR		AUTHORIZED	SIGNATURE	
B. DATE TERMINATED (POSITION OR TITLE)							