

## DENTAL CLAIM FORM

<b>PART 1 - DENTIST</b>	UNIQUE NO. <input type="checkbox"/> SPEC. <input type="checkbox"/> PATIENT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER
P A T I E N T	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	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.
DUPLICATE FORM <input type="checkbox"/>	OFFICE VERIFICATION/DENTIST'S SIGNATURE

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

<b>PART 2 - EMPLOYEE / PLAN MEMBER / SUBSCRIBER</b>			
1. GROUP POLICY / PLAN NO. _____ DIVISION / SECTION NO. _____ EMPLOYER _____ NAME OF INSURING AGENCY OR PLAN <b>CLAIMSECURE</b>	2. YOUR NAME (PLEASE PRINT) _____ YOUR CERTIFICATE NO. _____ OR S.I.N. OR I.D. NO. _____ YOUR DATE OF BIRTH _____ DAY MONTH YEAR		

<b>PART 3 - PATIENT INFORMATION</b>	
1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER / SUBSCRIBER _____ DATE OF BIRTH _____ DAY MONTH YEAR IF CHILD, INDICATE STUDENT <input type="checkbox"/> HANDICAPPED <input type="checkbox"/> IF STUDENT, INDICATE SCHOOL _____ PATIENT I.D. NO. _____  2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN <input type="checkbox"/> NO <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/> YES 4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT <input type="checkbox"/> NO <input type="checkbox"/> YES 5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? <input type="checkbox"/> NO <input type="checkbox"/> 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 _____

<b>PART 4 - POLICY HOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE, SEE ABOVE*)</b>										
1. DATE COVERAGE COMMENCED		DAY	MONTH	YEAR	CONTRACT HOLDER		DAY	MONTH	YEAR	AUTHORIZED SIGNATURE  (POSITION OR TITLE)
2. DATE DEPENDENT COVERED										
3. DATE TERMINATED										