Dental Claim Form

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

Carrier Name and Address:

PATIENT COMPLETES

Patient Name (first / m.i. / last)	Relationship to employee	Sex	Patient Birthdate (mm dd yyyy)	If a full time student, print school and attach student enrollment documentation.
	☐ Self ☐ Child ☐ Spouse ☐ Other_____	☐ M ☐ F		

Employee/subscriber name and mailing address	Employee/subscriber social security number	Employee/subscriber birthdate (mm dd yyyy)	Employer (company) name and address	Group Number

Is patient covered by another dental plan? ☐ Yes ☐ No	Name and address of other carrier(s)	Group number(s)	Name and address of other employer(s)

Employee/subscriber name (if different from patient(s)	Employee/subscriber social security number	Employee/subscriber birthdate (mm dd yyyy)	Relationship to patient ☐ Self ☐ Parent ☐ Spouse ☐ Other_____

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services not paid by my dental benefit plan. I authorize release of any information relating to this claim.

Signed (patient or legal guardian) _____ **Date** _____

I hereby authorize payment directly to the below-named dentist(s) of the group insurance benefits otherwise payable to me.

Signed (insured) _____ **Date** _____

DENTIST COMPLETES

Dentist Name	Is treatment result of occupational illness or injury?	**No**	**Yes**	
Mailing Address	Is treatment result of auto accident?			
City, State, Zip	Other accident?			

Dentist Soc. Sec. Or T.I.N.	Dentist license no.	Dentist Phone No.	If prosthesis, is this initial placement?		(If no, reason for replacement)	Date of prior placement

First visit date current series	Place of Treatment Office Hosp. ECF Other	Radiographs or models enclosed?	No	Yes	How many	Is treatment for orthodontics?			If service already Commenced, enter:	Date appliances placed	Mos. remaining
	| | |									|	|

Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32

Tooth no. or letter	Surface	Description of Service including x-rays, prophylaxis, materials used, etc.	Date Service Performed MO	DAY	YR	Procedure Number	Fee	
						Total fee Charged		

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 and intend to collect for those procedures. For pre-treament estimates, the fees submitted are the actual fees I intend to collect for those procedures.

Signed (Treating Dentist) Date