





STANDARD DENTAL **CLAIM FORM**

Association								_				_					
PART 1 DENTIST					UNIQUE NO. OFFICE NO.				PATIENT OFFICE ACCT NO.				I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER.				
P A T I				D E N T													
E I S												<u>x</u>					
T PHONE NO.								SIGNATURE OF SUBSCRIBER									
FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION,	, DIAGNOSIS, PRC	OCEDURES, OF	R SPECIAL (CONSIDERAT	TIONS.			S RENDER FORM TO COMMU	D MY PLAI NTIST FOR RED. I AU TO MY INS JNICATION	THAT THE FEES N BENEFITS. I R THE ENTIRE IS ACCUR UTHORIZE RELI SURING COMPA N OF INFORMA HIS FORM TO T	UNDERSTAN FREATMENT. FATE AND HA EASE OF THE INY / PLAN AI TION RELATE THE NAMED I	D THAT I AM I ACKNOWLE S BEEN CHAF INFORMATIO DMINISTRATO TO THE CO	FINANCIALLY EDGE THAT T RGED TO ME DN CONTAINI DR. I ALSO A	Y RESPON: THE TOTAL FOR SERVED IN THIS UTHORIZE	SIBLE TO FEE OF /ICES CLAIM	Y	
							SIGNATURE OF PATIENT (PARENT/GUARDIAN)										
								OFFICE	VERIFICA	TION				(
DUPLICATE FORM []																	
DATE PRO- INTL.													FOR CARRI	ER USE			
OF SERVICE CEDURI DAY MO. YR. CODE		OTH ODE	TOO				ORATOR HARGE	RY	TOTA		ALLOWE	D AMOUNT	INC	%	PATIE	ENT'S SHARE	
											_						
											_						
											_						
											CHEQUE N	Ю.		DATE			
											DEDUCTIB	LE	PATIENT PA	AYS	PLAN PA	AYS	
THIS IS AN ACCURATE STATEMENT OF AND THE TOTAL FEE DUE AND PAYABL		PERFOR	RMED		TOTA	AL FEE SUBMIT	TED \$				CLAIM NO.						
INSTRUCTIONS FOR CLAIM SUBMIS																	
BEING A STANDARD FORM, THIS FORM CANNOT PLAN BOOKLET, YOUR CERTIFICATE OR FROM IF YOUR PLAN REQUIRES SUBMISSION DIRECT! "IF YOUR PLAN REQUIRES SUBMISSION TO YOU	YOUR EMPLOY LY TO THE CAP IR EMPLOYER,	YER. RRIER, PLE , PLEASE D	EASE SEN	D THIS FOI	RM WITH	ONLY PARTS 1, 2 AND	3 COMPLET	ED TO THE	CARRIER'S	APPROPRIATE CI	AIMS OFFICE.						
PART 2 - EMPLOYEE/PLAN MEMBEI	R/SUBSCR	RIBER		DIVISION	WECT	ION NO		2 701	ID NAME	(DI EASE DOIN)	Γ\						
1. GROUP POLICY/PLAN NO.			— '	DIVIDION	W/OLOT				JK NAME	(PLEASE PRIN							
EMPLOYER							YOUR	YOUR CERT. NO. OR S.I.N. OR I.D. NO. For Dep. #									
NAME OF INSURING AGENCY OR PLAN								YOUR	DATE OF	_	AY MONTH	YEAR					
PART 3 - PATIENT INFORMATION																	
1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER										TMENT REQUI			AN ACCIDENT	Γ?	NO	YES	
DATE OF BIRTH IF CHILD INDICATE: STUDENT HANDICAPPED							4. IF E	IF YES, GIVE DATE AND DETAILS SEPARATELY. 4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OR PRIOR PLACEMENT AND REASON FOR REPLACEMENT. OUT OF THE PLACEMENT AND REASON FOR REPLACEMENT.									
IF STUDENT, INDICATE SCHOOL								-5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSE?									
PATIENT I.D. NO.										THE RELEASI						_	
2. ARE ANY DENTAL BENEFITS OR SER\ OR DENTAL PLAN, W.C.B. OR GOV'T F		VIDED UN	NDER AN		ER GRC YES	OUP INSURANCE		THA		F THIS CLAIM T IFORMATION G VLEDGE.			AND COMPL	ETE TO TH			
POLICY NO.		SF	POUSE I	DATE OF	BIRTH	·							DA		MONTH YI	EAR	
NAME OF OTHER INSURING AGENCY	OR PLAN							X SIGN		OF EMPLOYEE/	PLAN MEMBE	R/SUBSCRIR	ER				
PART 4 - POLICY HOLDER/EMPLOY	ER (FOR C	OMPLE	TION C	NLY IF	APPL	ICABLE. SEE ABO	OVE*)										
	DAY		NTH	YEAF	=					DATE							
1. DATE COVERAGE COMMENCED 4. CONTRACT HOLDER 2. DATE DEPENDENT COVERED 4. CONTRACT HOLDER						IOLDER						AUTHOR	RIZED SIGN	NATURE			
	, ,								DAY	MONTH	YEAR						