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**CLAIM FORM**  
**DENTAL CARE**

**PART 1: DENTIST'S STATEMENT**

Patient (Last and first name) _____ For dentist's use only to provide additional information, diagnosis, procedures, or special considerations:  Duplicate <input type="checkbox"/> Predetermination <input type="checkbox"/>	Dentist (Last and first name / Address / Phone no.) _____ _____ _____ I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her. _____ Signature of subscriber I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of \$ _____ is accurate and has been charged to me for services rendered. Member's signature _____ Verification (Dentist) _____
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**Treatment and services rendered to the patient**

Date of service			Procedure code	Internal tooth code	Tooth surfaces	Dentist's fees	Laboratory charges	Total charges
Y	M	D						

Excluding possible errors or omissions, this is an accurate statement of services performed and the total fee due and payable.

**Total fee submitted**  

**PART 2: POLICYHOLDER'S STATEMENT (Complete only if your group is self-administered)**

<b>Member:</b>	Effective date	Y	M	D	Termination date	Y	M	D
<b>Spouse:</b>	Effective date				Termination date			
<b>Child:</b>	Effective date				Termination date			

Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

**PART 3: MEMBER'S STATEMENT**

Policyholder's name \_\_\_\_\_

Policy no. \_\_\_\_\_ Division no. \_\_\_\_\_ Class no. \_\_\_\_\_

Member's last name \_\_\_\_\_ First name \_\_\_\_\_

Certificate no. \_\_\_\_\_ Date of birth Y M D Sex:  M  F Language:  E  F

**COORDINATION OF BENEFITS**

**IMPORTANT NOTE:**  
 Under the coordination of benefits section of your plan, if your spouse is covered under a dental care benefit, the expenses incurred by your spouse must first be submitted to his or her insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.  
 The expenses incurred by insured dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Is your spouse, if applicable, covered by another group plan?  No  Yes, specify:

Name of insurance company \_\_\_\_\_ Policy no. \_\_\_\_\_ Coverage:  Individual  Family

Name of Spouse \_\_\_\_\_ Date of birth Y M D \_\_\_\_\_

