



## STANDARD DENTAL CLAIM FORM

™ Insurance Association inc.																														
PART 1 DENTIST									U	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	FIRST NA ADDRESS							N T	D E N T I S T PHONE NO.																					
									T												SIGNATURE OF SUBSCRIBER									
FOF	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 BENETIETS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATME I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ 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 COVERAG OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.  SIGNATURE OF PATIENT (PARENT/GUARDIAN)  OFFICE VERIFICATION										THE ENTIRE TREATMENT. EN CHARGED TO ME FOR SURING COMPANY / NIED TO THE COVERAGE				
DATE OF SERVICE PROCEDURE INTL. TOOTH									DENTIST'S					LABORATORY			TOTAL													
DAY	Y MO. YR.		_	CODE				TOOTH	CODE	SURFACES	4	FEE			+	C	HAR	ijE T	E CHARGES			GES	FOR CARRIER USE							
																								AL	LOWED AMOUNT	INC	%	PATIENT'S SHARE		
																						СНЕ			JE NO. DATE					
																								DEDI	JCTIBLE P/	ATIENT PAY	'S	PLAN PAYS		
ANI	THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE SUBMITTED  TOTAL FEE SUBMITTED													D D		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.																														
PA	RT 2 -	EMPL	OYE	E/PL	_AN	MEN	IBER	R/SUI	BSCF	RIBER																				
1. (	ROUP PO	LICY/PL/	AN NO.						DI	VISION/SECTIO	N NO	)						2. YOUR NAME (PLEASE PRINT)												
EM	PLOYER _															_	YOUR CERT. NO. OR S.I.N. OR I.D. NO.													
NA	ME OF INS	URING A	GENC	Y OR P	LAN_											_	YOUR DATE OF BIRTHDAY MONTH YEAR													
P	PART 3 - PATIENT INFORMATION																													
1. I	1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER													_	3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? NO YES															
	D	ATE OF B	IRTH _	DAY	M	ONTH	YE	AR	IF CHII	D INDICATE: [	STI	UDENT		HANDI	CAPPE	D	4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.   NO YES													
	IF	STUDEN	IT, IND	ICATE	SCHO	DL										_	5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES?													
2	PATIENT I.D. NO													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.																
ı	PLAN, W.C	.B. OR G	OV'T P	LAN?		NO		YES									DATE													
POLICY NO SPOUSE DATE OF BIRTH  Name of other insuring agency or plan															SIGNATII	RF NF	FMP	OYFF	/PI AN MFI	MBER/SUBSO	ERIRER	ļ	DAT N	IONTH YEAR						
																_						-0 1 LE	, MIEI							
P/	RT 4.	- POLI	CY	1011	UER/		LUY			COMPLET	ION	ON	Υİ	Al	PLI0	AB	4			/E*)		7								
1.1	DATE COVI	ERAGE C	OMMF	NCED	-	DAY	+	MONT	Н	YEAR	4. CONTRACT HOLDER			DER			$\top$	DATE	AUTHORIZED SIGNATURE											
	DATE DEPE								John Holdell				DAY		10NTH	YEA	R				AUTHORIZ	JIGHA	·							
3. I	DATE TERM	/INATED																							(POSITI	ON OR TITI	.E)			