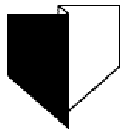
Dental Claim Form



MERITAIN℠ HEALTH

Complete and send to:
Meritain Health
P.O. Box 27267
Minneapolis, MN 55427-0267
Fax: 952.541.0193

IMPORTANT: Please have your dentist or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

1 EMPLOYEE INFORMATION

Name *(last, first, initial)*		Sex	Employer Name	
Home Address		Identification Number	Birthdate	Group Number
City	State	ZIP Code	Work Telephone ( )	Home Telephone ( )

2 PATIENT INFORMATION

The Patient is: ❑ THE EMPLOYEE *(go to No. 3)* ❑ EMPLOYEE'S SPOUSE *(complete spouse information)* ❑ EMPLOYEE'S CHILD *(complete spouse and child information)*

Spouse's Name (last, first, initial)		Sex	Child's Name (last, first, initial)		Sex
Spouse's Birthdate	Spouse's Social Security Number		Child's Birthdate	Child's Social Security Number	
Spouse's Employer			*If child is over age 19 and full-time student, complete:* Name of School:		
Spouse's Employer's Address			School Address		

3 OTHER COVERAGE

❑ YES *(then complete)* ❑ NO *(go to No. 4)* NAME OF POLICYHOLDER:

Name of Other Health Insurance Carrier or Plan	Address	City		State	ZIP Code
Other Insurance Carrier's or Plan's Telphone No.	Type of Coverage ❑ GROUP ❑ INDIVIDUAL	Group Number	Contract or Policy Number		
Spouse's Employer		*If child is over age 19 and full-time student, complete:* Name of School:			
Spouse's Employer's Address		School Address			

4 ABOUT THIS CLAIM

❑ INJURY ❑ ILLNESS
Date and time of accident:

Describe injury, when and how it happened or nature of illness:

Was injury the result of auto accident? ❑ YES ❑ NO
If auto insurance involved, please provide: Policy No | Name of Insurance Company | Address (City, State, ZIP Code)

Work related injury? ❑ YES ❑ NO

If injury is work related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.

5 EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

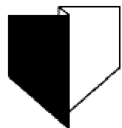
Signature ______________________ Date ______________

6 ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)

I authorize payment of benefits directly to the dentist or supplier of services listed here.

Provider to be paid ______________________ Employee's Signature ______________________

Provider's Tax ID No.
or Social Security No. [ ] Date ______________________



MERITAIN HEALTH

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PHYSICIAN OR SUPPLIER STATEMENT

A

Patient Name (last, first, middle initial)	Birthdate
Address	

B

Dentist's Name			
Address			
City	State	ZIP Code	Telephone ( )

Provider's Tax ID No. or SSN: ______ Dentist's License No.:

C

Question	Answer	Details
Is treatment a result of injury arising from patient's employment?	❑ YES ❑ NO	If yes, description and date:
Is treatment the result of an auto accident?	❑ YES ❑ NO	If yes, description and date:
Are any services covered by another plan?	❑ YES ❑ NO	If yes, name of other plan:
If prosthesis, is this an initial placement?	❑ YES ❑ NO	If no, reason for placement and date of previous placement:
Is treatment for orthodontics?	❑ YES ❑ NO	Date appliances placed: Mo. of treatment remaining:

D

Is this claim for a pre-treatment estimate? ❑ YES ❑ NO If yes, are x-rays enclosed? ❑ YES ❑ NO

E

EXAMINATION AND TREATMENT RECORD

LABIAL
LINGUAL
UPPER
RIGHT
LEFT
PRIMARY
PERMANENT
LOWER
LINGUAL
LABIAL
Indicate missing teeth with an "X"

Tooth No. or Letter	Surface	Procedure Number (ADA)	Description of Services (include x-rays, prophylaxis, materials used, etc.)	Date of Service	Charges

F

I hereby certify that the above procedures have been completed on the date indicated.

Dentist's Signature ______________________ Date ______________

STATUS AND BENEFIT INFORMATION:
1-800-925-2272

Send to:
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