

DENTAL CLAIM FORM

PATIENT SECTION

ATTENDING DENTIST'S STATEMENT <input type="checkbox"/> PRETREATMENT REQUEST <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES	PATIENT ACCOUNT NUMBER
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1. PATIENT NAME (LAST) (FIRST) (INITIAL)		2. RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	
3. SEX <input type="checkbox"/> M <input type="checkbox"/> F	4. PATIENT BIRTH DATE MONTH DAY YEAR	5. IF FULL TIME STUDENT	CITY STATE
6. SUBSCRIBER NAME (LAST) (FIRST) (INITIAL)		7. SUBSCRIBER IDENTIFICATION NUMBER	
8. SUBSCRIBER ADDRESS (STREET OR RFD NUMBER, CITY, STATE, ZIP CODE)		9. EMPLOYER NAME AND ADDRESS (STREET, CITY, STATE, ZIP)	
10. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		DENTAL PLAN NAME	UNION LOCAL GROUP NUMBER
NAME AND ADDRESS OF OTHER INSURANCE COMPANY			

I hereby accept the treatment below and authorize release of any information relating to this claim.
 PATIENT/PARENT OR EMPLOYEE-MEMBER SIGNATURE _____ DATE _____

DENTIST SECTION

PLEASE PROVIDE TOOTH NUMBERS WHEN REQUIRED

11. DENTIST NAME	12. ADDRESS (STREET, CITY, STATE, ZIP)	16. IS TREATMENT A RESULT OF OCCUPATIONAL INJURY?	YES	NO	IF YES, ENTER BRIEF DESCRIPTION AND DATES		
		17. IS TREATMENT A RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?					
13. TAX I.D. NUMBER	14. DENTIST LICENSE NUMBER	15. DENTIST PHONE NUMBER	18. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED, ENTER	DATE APPLIANCES PLACED	MONTHS TREATMENT REMAINING
			19. IF PROTHESIS, IS THIS INITIAL PLACEMENT?		IF NO, REASON FOR REPLACEMENT	20. DATE OF PRIOR PLACEMENT	

DIAGNOSTIC AND TREATMENT RECORD

LIST IN TOOTH ORDER (1 - 32 OR A - T)

ARE X-RAYS OR OTHER REVIEW DOCUMENTS ATTACHED? YES NO 21. PLACE OF TREATMENT OFFICE HOSPITAL OTHER

TOOTH # OR LETTER	QUAD	SURFACES	DESCRIPTION OF SERVICE	COMPLETION DATE MONTH / DATE / YEAR	PROCEDURE CODE	CHARGE
			1.)			
			2.)			
			3.)			
			4.)			
			5.)			
			6.)			
			7.)			
			8.)			
			9.)			
			10.)			

22. IDENTIFY ALL MISSING TEETH WITH AN X:

PERMANENT																PRIMARY									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

TOTAL	
LESS THIRD PARTY PAYMENTS	
NET CHARGE	

I hereby certify that the services listed above have been completed and to the best of my knowledge are within the provisions of the plan, payment is therefore due.

TREATING DENTIST SIGNATURE _____ DATE _____