

DENTAL CLAIM FORM

CARRIER NAME AND ADDRESS

Check one:

- Dentist's pre-treatment estimate
- Dentist's statement of actual services

PATIENT COVERAGE INFORMATION

1. Patient's name first m.i. last	2. Relationship to employee self child spouse other	3. Sex m f	4. Patient birthdate MM DD YYYY	5. If full time student school city
6. Employee/subscriber name and mailing address	7. Employee/subscriber soc. sec. or I.D. number	8. Employee/subscriber birthdate MM DD YYYY	9. Employer (company) name and address	10. Group number
11. Is patient covered by another dental plan? yes no If yes, complete 12-a. Is patient covered by a medical plan? yes no	12-a. Name and address of carrier(s)	12-b. Group no. (s)	13. Name and address of other employer (s)	
14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. or I.D. number	14-c. Employee/subscriber birthdate MM DD YYYY	15. Relationship to patient self spouse parent other	

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signed (Patient, or parent if minor) _____ Date _____

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (insured person) _____ Date _____

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity Paul S. Burkey, D.D.S., M.S.			24. Is treatment result of occupational illness or injury? No Yes		If yes, enter brief description and dates.	
17. Address where payment should be remitted 290 Center Drive City, State, Zip Vernon Hills, IL 60061			25. Is treatment result of auto accident?			
18. Dentist Soc. Sec. or T.I.N.			19. Dentist license no.		20. Dentist phone no. 847/367-1640	
21. First visit date current series		22. Place of treatment Office Hosp. ECF Other		23. Radiographs or models enclosed? No Yes How many?		26. Other accident?
27. If prosthesis, is this initial placement?			28. Date of prior placement		(if no, reason for replacement)	
29. Is treatment for orthodontics?			If services already commenced enter: Date appliances placed Mos. treat. remain.			

Identify missing teeth with "x"

30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed			Procedure number	Fee	For administrative use only
			Mo.	Day	Year			

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Treating Dentist)

License Number

Date

Total Fee Charged

Max. Allowable

Deductible

Carrier %