Group Dental Claim Form

P.O. Box 7777, Lancaster, PA 17604-7777 Ph. 717-581-1300 1-800-433-3746 Fax 717-581-8379

TO BE COMPLETED BY EMPLOYEE

1. Patient Name:	2. Relationship to Employee ❒ Self ❒ Spouse ❒ Child ❒ Other	3. Sex ❒ M ❒ F	4. Patient Birth date / /	
5. Employee/Member/Subscriber Name (First, Middle, Last)	6. Employee Member ID	Employee Birth Date / /		
7. Employee Mailing Address	8. Company (employer) name and address and/or division and plant location			
9. Account/Policy #	10. Is spouse or other family member employed? ❒ Yes ❒ No If yes, Members Name: Insurance/Plan ID _____ / _____ / ________	11. Name and Address of spouse's or other family member's employer in item 11: Spouse's Birth Date _____ / _____ / _____		
12. Is patient covered by another dental plan? ❒ Yes ❒ No If yes, indicate	Dental Plan Name	Group Number	Name and Address of Carrier	
AUTHORIZATION TO PAY BENEFITS TO DENTIST-I hereby authorize payment directly to the below named Dentist of the Dental benefits otherwise payable to me.	Signed (employee)	Date		
CERTIFICATION-I certify that the foregoing information is true and correct	Signed (employee)	Date		

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR PLAN, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

TO BE COMPLETED BY ATTENDING DENTIST

13. Dentist Name	21. Is treatment result of an occupational illness or injury? ❒ Yes ❒ No	If yes, enter brief description and dates
14. Mailing Address	22. Is treatment result of auto accident? ❒ Yes ❒ No	
City, State, Zip	23. Other ❒ Yes ❒ No	

15. Tax I.D.# Soc. Sec.# To be used for tax reporting	16. Dentist License No.	24. Are any services covered by another plan? ❒ Yes ❒ No If yes, Name of other plan:		
17. Dentist Phone No.	18. First visit date current series:	25. If prosthesis, is this initial placement? ❒ Yes ❒ No	(If no, reason for replacement):	26. Date of prior placement:

19. Place of Treatment Office Hosp. ECF Other ❒ ❒ ❒ ❒	20. Radiographs or models enclosed? ❒ Yes ❒ No How many?	27. Is treatment for orthodontics? ❒ Yes ❒ No	If services already commenced enter	Date Appliances:	Mos. Treatment:

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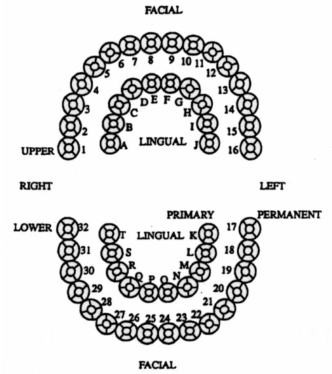
ΛOVER

29. Examination and treatment plan-list in order from tooth no. 1 through tooth no. 32-use charting system shown



Tooth # or Letter	Surface (i.e. M,O,D,B,L,LA,I)	Description of Service (including X-Rays, Prophylaxis, Materials Used)	Date Service Completed Mo. Day Year	Procedure Number	Fee	Indicate missing teeth with an "X"

30. Remarks for unusual services

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE, HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.	Signed (Dentist) ____________________	Date	Total Fee Charged	