



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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	3. Sex <input type="checkbox"/> M <input type="checkbox"/> F	4. Patient Birth date / /	5. If full time student School City
6. Employee/Member/Subscriber Name (First, Middle, Last)		7. Employee Social Security Number	Employee Birth Date / /	
8. Employee Mailing Address _____ _____		9. Company (employer) name and address and/or division and plant location _____ _____ _____		
10. Account/Policy #	11. Is spouse or other family member employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Members Name: Social Security Number ____ / ____ / _____	12. Name and Address of spouse's or other family member's employer in item 11: Spouse's Birth Date ____ / ____ / _____		

13. Is patient covered by another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate	Dental Plan Name	Group Number	Name and Address of Carrier
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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
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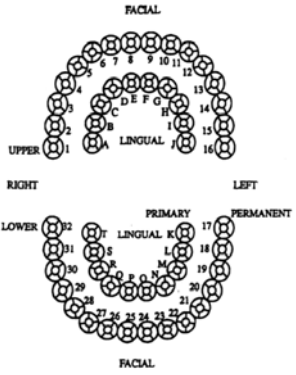
CERTIFICATION-I certify that the foregoing information is true and correct	Signed (employee) _____	Date
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ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR PLAN, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION 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

14. Dentist Name	22. Is treatment result of an occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, enter brief description and dates			
15. Mailing Address	23. Is treatment result of auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No				
City, State, Zip	24. Other <input type="checkbox"/> Yes <input type="checkbox"/> No				
16. Tax I.D.# _____ Soc. Sec.# _____ To be used for tax reporting	17. Dentist License No.	25. Are any services covered by another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name of other plan:			
18. Dentist Phone No.	19. First visit date current series:	26. If prosthesis, is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No	(If no, reason for replacement):	27. Date of prior placement:	
20. Place of Treatment Office Hosp. ECF Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	21. Radiographs or models enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No How many?	28. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No	If services already commenced enter	Date Appliances:	Mos. Treatment:

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