HealthSCOPE BENEFITS

DENTAL CLAIM FORM

It is a crime to complete this form with information that you know is false or to omit any facts that you know are important.

EMPLOYEE / MEMBER SECTION:

Complete this section before taking this form to your dentist.
Send completed claim form and all related bills to the claim office address shown on your ID card.

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)	RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER	SEX M F	PATIENT'S BIRTHDATE MO. DAY YR.	IF FULL TIME STUDENT, SCHOOL / CITY

EMPLOYEE/MEMBER NAME (FIRST, MIDDLE INITIAL, LAST)	EMPLOYEE/MEMBER SOC. SEC. NO.	GROUP NAME (E.G. EMPLOYER)

ADDRESS, STREET ☐ **Check Box if New Address**	EMPLOYER ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP

GROUP POLICY NUMBER	ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO EMPLOYEE NAME SOC. SEC. NO. IF YES,	NAME AND ADDRESS OF EMPLOYER
EMPLOYEE/MEMBER BIRTHDATE MO. DAY YR.	IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO IF YES, GIVE GROUP NAME UNION LOCAL GROUP NO.	NAME AND ADDRESS OF CARRIER PROVIDING BENEFITS

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS REQUEST.
I CERTIFY THE ABOVE IS TRUE AND CORRECT.

► _____ MO. DAY YR. _____
SIGNED (PATIENT OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE BENEFITS OTHERWISE PAYABLE TO ME.

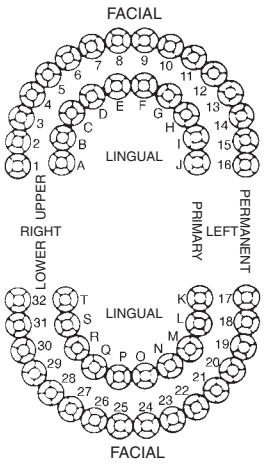
► _____ MO. DAY YR. _____
SIGNED (EMPLOYEE/MEMBER) DATE

DENTIST SECTION:

DENTIST NAME			IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
ADDRESS, STREET			IS TREATMENT RESULT OF AUTO ACCIDENT?			
			OTHER ACCIDENT?			
CITY, STATE, ZIP			ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SOC. SEC. NO. OR TAX I.D. NO.	DENTIST LICENSE NO.	DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO. REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT
FIRST VISIT DATE	PLACE OF TREATMENT OFFICE HOSP. ECF OTHER	RADIOGRAPHS OR MODELS ENCLOSED NO YES HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

CHECK ONE: ☐ DENTIST'S PRE-TREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES PERFORMED

INDICATE MISSING TEETH WITH AN "X"



EXAMINATION AND TREATMENT PLAN -- LIST IN ORDER FROM TOOTH NO. 1 THROUGH 32. USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.	DATE SERVICE PERFORMED MO.	DAY	YR.	PROCEDURE NUMBER	FEE	
						TOTAL		

REMARKS:

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE DATES INDICATED.

DENTIST'S SIGNATURE: **DATE:**

I HEREBY CERTIFY THAT I HAVE REVIEWED THE PLAN OF TREATMENT AND THE FEES TO BE CHARGED, AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THE PLAN.

EMPLOYEE / MEMBER SIGNATURE: **DATE:**

FOR OFFICE USE ONLY

Verifier	Date	Employee/Member Soc. Sec. No.	Effective Date	Dependent Effective Date

Class or Policy Number Suffix	Termination Date (if applicable)