

Dental Claim Form



MERITAINSM
HEALTH

Please complete this form
and submit to the address
located on the back of your
member ID Card.

IMPORTANT: Please have your dentist or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

Section 1. EMPLOYEE INFORMATION					
Name (last, first, initial)			Sex	Employer Name	
Home Address			Identification Number	Birthdate	Group Number
City	State	Zip Code	Work Telephone ()	Home Telephone ()	

Section 2. PATIENT INFORMATION					
The patient is:	<input type="checkbox"/> The employee (Go to section 3)	<input type="checkbox"/> Employee's Spouse (Complete spouse information)	<input type="checkbox"/> Employee's Child (Complete spouse and child information)		
Spouse's Name (last, first, initial)		Sex	Child's Name (first, last, initial)		Sex
Spouse's Birthdate	Spouse's Social Security Number		Child's Birthdate	Child's Social Security Number	
Spouse's Employer			<i>If child is over age 19 and full-time student, complete:</i> Name of School:		
Spouse's Employer's Address			School Address		

Section 3. OTHER COVERAGE					
<input type="checkbox"/> Yes (then complete) <input type="checkbox"/> No (go to section 4)			Name of Policy Holder:		
Name of Other Health Insurance Carrier or Plan		Address		City	State Zip Code
Other Insurance Carrier's or Plan's Telephone #	Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual		Group Number	Contract or Policy Number	
Spouse's Employer			<i>If child is over age 19 and full-time student, complete:</i> Name of School:		
Spouse's Employer's Address			School Address		

Section 4. ABOUT THIS CLAIM	
<input type="checkbox"/> Injury <input type="checkbox"/> Illness Date and time of accident:	Describe injury, when and how it happened or nature of illness:
Was this injury the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If auto insurance was involved, please provide:	Policy # Name of insurance company Address (city, state, zip)
Was this a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	If injury is work-related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.

Section 5. EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED	
The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photo-static copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.	
Signature:	Date:

Section 6. ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)	
I authorize payment of benefits to the dentist or supplier of services listed here.	
Provider to be paid	Employee's Signature
Provider's tax ID number or Social Security Number	Date



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PHYSICIAN OR SUPPLIER STATEMENT

A	Patient Name (last, first, initial)		Birthdate					
	Address							
B	Dentist's Name							
	Address							
	City		State	Zip Code	Telephone			
	Provider's Tax ID Number or Social Security Number			Dentist's License Number:				
C	Is treatment a result of injury arising from patient's employment?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, description and date:				
	Is treatment the result of an auto accident?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, description and date:				
	Are any services covered by another plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of other plan:				
	If prosthesis, is this an initial placement?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, reason for placement and date of previous placement:				
	Is treatment for orthodontics?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Date appliances placed:	Mon. of treatment remaining:			
D	Is this claim for a pre-treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are X-rays enclosed?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
EXAMINATION AND TREATMENT RECORD								
E	<p>Indicate missing teeth with an "X"</p>	Tooth # or Letter	Surface	Procedure Number (ADA)	Description of Services (includes X-rays, prophylaxis, materials used, etc.)	Date of Service	Charges	
F	I hereby certify that the above procedures have been completed on the date indicated.							
	Dentist's Signature:			Date:				

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