

CLAIM FOR DENTAL BENEFITS

MERITAIN HEALTH
Please submit this form to the address located on the back of your ID card.

EMPLOYER _____

CHECK ONE: DENTISTS PRE-TREATMENT ESTIMATE DENTISTS STATEMENT OF ACTUAL SERVICES

PATIENT SECTION	1. PATIENT NAME Last First Middle Initial		2. RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD		3. SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. PATIENT BIRTHDATE Month / Day / Year		
	5. EMPLOYEE NAME Last First Middle Initial			6. EMPLOYEE ID NUMBER		7. EMPLOYEE'S MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			
	8. EMPLOYEE MAILING ADDRESS (If new address, contact your employer's personnel office to make the appropriate changes.) Street Address City State Zip								
	9. ARE OTHER FAMILY MEMBERS EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO Name Soc. Sec. No. RELATIONSHIP <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD					10. NAME AND ADDRESS OF EMPLOYER IN ITEM 9			
	11. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO DENTAL PLAN NAME GROUP #								
12. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO			13. IS TREATMENT RESULT OF AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		14. ENTER BRIEF DESCRIPTION OF ACCIDENT AND DATES				
15. AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any dentist, orthodontist, druggist, or any other Provider (including other insurance companies), Employer or Organization to release any information or view a copy of my records pertaining to the examination, treatment, history, prescriptions or dental expenses to Meritain Health, or its representatives, for the purpose of validating and determining benefits payable in connection with the claim. Furthermore, I understand that any person who, with intent to defraud or knowing that he/she is facilitating a fraud, submits an application for coverages or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Patient Signature (or parent if minor) _____ Date _____ By my signature, I acknowledge that payment of this claim is subject to the Plan's rights of subrogation and reimbursement, and to the coordination of benefits with any other coverage that the patient may have. Furthermore, I certify that the foregoing information is true and correct.									
16. PAYMENT AUTHORIZATION - I HEREBY AUTHORIZE PAYMENT FOR THESE BENEFITS BE SENT DIRECTLY TO (CHECK ONE): <input type="checkbox"/> PROVIDER OF SERVICE <input type="checkbox"/> EMPLOYEE (attach proof of payment or have provider mark this form <i>paid in full</i>) Patient Signature (or parent if minor) _____ Date _____									

DENTIST	17. DENTIST NAME		22. FIRST VISIT DATE CURRENT SERIES		23. PLACE OF TREATMENT <input type="checkbox"/> OFFICE <input type="checkbox"/> HOSP. <input type="checkbox"/> ECF <input type="checkbox"/> OTHER		24. RADIOGRAPHS OR MODELS ENCLOSED? <input type="checkbox"/> YES <input type="checkbox"/> NO		25. HOW MANY?		
	18. MAILING ADDRESS CITY, STATE, ZIP				26. ARE ANY SERVICES COVERED BY ANOTHER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE PROVIDE DETAILS				
	19. DENTIST SOC. SEC. NO. T.I.N.				20. DENTIST LICENSE NO.		21. DENTIST PHONE NO.		27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
					28. DATE OF PRIOR REPLACEMENT		IF SERVICES ALREADY COMMENCED: DATE APPLIANCES PLACED: MOS. TREATMENT REMAINING:				

<p>IDENTIFY MISSING TEETH WITH 'X'</p> <p>Root Canal Dates Open _____ Close _____</p> <p>Crown Dates Prep _____ Cement _____</p> <p>Prosthesis Dates Impress _____ Insert _____</p>	30. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 31 - USE CHARTING SYSTEM SHOWN							FOR ADMINISTRATIVE USE ONLY	
	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO. DAY YEAR			ADA PROCEDURE NUMBER		
I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.							TOTAL FEE CHARGED		
SIGNED (DENTIST) _____							DATE _____		