

Dental Claim Form

Check One: <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services				Carrier name and address: CompDent Insurance Services			Administered by CompDent P.O. Box 4605 Chicago, IL 60680-4605 (800) 456-5500	
PATIENT COVERED INFORMATION	1. Patient name first mi. last		2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____		3. Sex m f	4. Patient birthdate MM DD YYYY	5. If full time student School _____ City _____	
	6. Employee/subscriber name and mailing address		7. Employee/subscriber soc. sec. or I.D. #	8. Employee/subscriber birthdate MM DD YYYY	9. Employer (company) name and address		10. Group number	
	11. Is patient covered by another dental plan? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, complete 12-a. Is patient covered by a medical plan? <input type="checkbox"/> yes <input type="checkbox"/> no	12-a. Name and address of carrier(s)		12-b. Group no.(s)		13. Name and address of other employer(s)		
	14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. or I.D. #	14-c. Employee/subscriber birthdate MM DD YYYY	15. Relationship to beneficiary <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other _____				
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.				I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.				
Signed (Patient, or parent if minor) _____ Date _____				Signed (Insured person) _____ Date _____				
BILLING DENTIST	16. Name of Billing Dentist or Dental Entity			24. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates.				
	17. Address where payment should be remitted City, State, Zip			25. Is treatment result of auto accident?				
	18. Dentist Soc. Sec. or T.IN 19. Dentist license no. 20. Dentist phone no.			27. If prosthesis, is this initial placement? (If no, reason for replacement)		28. Date of prior placement		
	21. First visit date current series	22. Place of treatment Office Hsp. HCF Other	23. Radiographs or models enclosed? No Yes How Many?	29. Is treatment for orthodontics?		If services already commenced enter:	Date appliances placed	Mos. treatment remaining
Identify missing teeth with "x"		30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - 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	Procedure number	Fee	
31. Remarks for unusual services								
I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.						Total Fee Charged		
Signed (Treating Dentist) _____ License Number _____ Date _____						Max Allowable		
Full mouth radiographs and complete mouth charting must accompany claim form for major restorative and/or periodontal therapy.						Deductible		
						Carrier %		
						Carrier Pays		
						Patient Pays		

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the Plan, files a claim containing a false or deceptive statement is guilty of insurance fraud.