Dental Claim Form

MERITAIN 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: ☐ **The employee** (Go to section 3) ☐ **Employee's Spouse** (Complete spouse information) ☐ **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		*If child is over age 19 and full-time student, complete:* **Name of School:**	
Spouse's Employer's Address		School Address	

Section 3. OTHER COVERAGE

☐ **Yes** (then complete) ☐ **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 ☐ **Group** ☐ **Individual**	Group Number	Contract or Policy Number	
Spouse's Employer		*If child is over age 19 and full-time student, complete:* **Name of School:**		
Spouse's Employer's Address		School Address		

Section 4. ABOUT THIS CLAIM

☐ **Injury** ☐ **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? ☐ **Yes** ☐ **No**

If auto insurance was involved, please provide:	**Policy #**	**Name of insurance company**	**Address (city, state, zip)**

Was this a work-related injury? ☐ **Yes** ☐ **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

MERITAIN HEALTH

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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

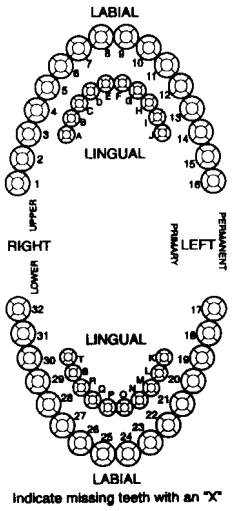
Is treatment a result of injury arising from patient's employment?	☐ Yes ☐ No	If yes, description and date:	
Is treatment the result of an auto accident?	☐ Yes ☐ No	If yes, description and date:	
Are any services covered by another plan?	☐ Yes ☐ No	If yes, name of other plan:	
If prosthesis, is this an initial placement?	☐ Yes ☐ No	If no, reason for placement and date of previous placement:	
Is treatment for orthodontics?	☐ Yes ☐ No	Date appliances placed:	Mon. of treatment remaining:

D

Is this claim for a pre-treatment?	☐ Yes ☐ No	If yes, are X-rays enclosed?	☐ Yes ☐ No

E

EXAMINATION AND TREATMENT RECORD



Indicate missing teeth with an "X"

Tooth # or Latter	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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