18002 Cowan
Irvine, CA 92614

CLAIM FOR DENTAL EXPENSE BENEFITS

TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE — SELF / SPOUSE / CHILD / OTHER
3. SEX — M / F
4. PATIENT BIRTHDAY — MO / DAY / YEAR
5. IF FULL TIME STUDENT — SCHOOL / CITY
6. EMPLOYEE NAME — FIRST / MIDDLE / LAST
7. EMPLOYEE SOC. SEC. NO
9. NAME OF GROUP DENTAL PROGRAM
8. EMPLOYEE MAILING ADDRESS
CITY, STATE — ZIP
10. EMPLOYER (COMPANY) NAME AND ADDRESS
11. GROUP NUMBER
12. BRANCH
13. ARE OTHER FAMILY MEMBERS EMPLOYED? NO YES — EMPLOYEE NAME / SOC. SEC. NO
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO ☐ YES ☐ IF YES, GIVE — DENTAL PLAN NAME / UNION LOCAL / GROUP NO. / NAME AND ADDRESS OF CARRIER

15a. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

PATIENT'S SIGNATURE (PARENT IF A MINOR) ________ DATE ________

15b. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

EMPLOYEE'S SIGNATURE ________ DATE ________

TO BE COMPLETED BY DENTIST

16. DENTIST NAME — FIRST / MIDDLE / LAST
17. MAILING ADDRESS
CITY, STATE — ZIP
18. DENTIST SOC. SEC. OR T.I.N.
19. DENTIST LICENSE NO.
20. PHONE NUMBER

	NO	YES	IF YES, ENTER DESCRIPTION/DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON) 29. DATE OF PRIOR PLACEMENT

21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT — OFFICE / HOSP / ECF / OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? NO / YES / HOW MANY
30. IS TREATMENT FOR ORTHODONTICS? ☐ NO ☐ YES — IF SERVICES ALREADY COMMENCED, ENTER DATE PLACED / MOS REMAINING

DENTIST - CHECK ONE
☐ PRETREATMENT ESTIMATE
☐ STATEMENT OF ACTUAL SERVICES
IDENTIFY MISSING TEETH WITH "X"

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

31. EXAMINIATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU TOOTH NO. 32

Tooth No. or Ltr	Surface	DESCRIPTION OF SERVICCES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Date Service Perfomed Mo.	Day	Yr.	Procedure Number	FEE	ADMINISTRATIVE USE ONLY — BASIC	MAJOR

32. REMARKS FOR UNUSAL SERVICES

Total Fee Charged

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN BENEFITS PAYABLE TO THE ATTENDING DENTIST.

EMPLOYEE'S SIGNATURE ________ DATE ________

TO BE COMPLETED BY DENTIST

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE ABOVE-NAMED PATIENT ON THE DATES INDICATED

DENTIST'S SIGNATURE DATE

EXAMINER TRANSACTION # CHECK DATE

DENTAL UNIT USE

Employee Eligible Date ___________
Employee Effective Date __________
Termination Date _____________
Coverage Code ______________
Verified By ______________
Date ____________________

Predetermination is valid for 90 days from the date above.

	BASIC	MAJOR
Deductible		
Balance		
% Payable	%	%
Amt Payable		

These benefits will, subject to Plan provsiions, be payable if the described procedures, are performed during a period of the patient's eligibility

(The patient's personal eligibility has not been verified at the time of predetermination)