Dental Claim Form

Check One:
❑ **Dentist's pre-treatment estimate**
❑ **Dentist's statement of actual services**

Carrier name and address:
CompBenefits Insurance Services

CompBenefits-CLAIMS
P.O. Box 8236
Chicago, IL 60680

PATIENT COVERAGE INFORMATION

1. Patient name — first / m.i. / last
2. Relationship to employee — ❑ self ❑ child ❑ spouse ❑ 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? ❑ yes ❑ no — If yes, complete 12-a. Is patient covered by a medical plan? ❑ yes ❑ no
12-a. Name and address of carrier(s) — **Baptist Health South Florida, Inc.**
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 — ❑ self ❑ parent ❑ spouse ❑ 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.

▶ _____ Signed (Patient, or parent if minor) _____ Date

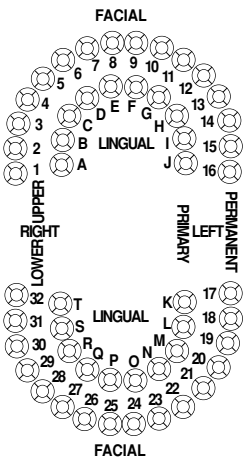
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

▶ _____ Signed (Insured person) _____ Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Address where payment should be remitted
City, State, Zip
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment — Office Hosp. ECF Other
23. Radiographs or models enclosed? — No Yes How Many?
24. Is treatment result of occupational illness or injury? — No Yes — If yes, enter brief description and dates.
25. Is treatment result of auto accident? — No Yes
26. Other accident? — No Yes
27. If prosthesis, is this initial placement? — No Yes — (If no, reason for replacement)
28. Date of prior placement
29. Is treatment for orthodontics? — No Yes — 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.

Tooth # or Letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

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.

▶ _____ Signed (Treating Dentist) _____ License Number _____ Date

Total Fee Charged

Max Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	

Full mouth radiographs and complete mouth charting must accompany claim form for major restorative and/or periodontal therapy.

Any person who knowingly and with intent to defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.