Dental Claim Form

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

CompBenefits

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

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 I.D. #
8. Employee/subscriber birthdate — MM / DD / YYYY
9. Employer (company) name and address — City of Chicago
10. Group number — 1873
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)

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 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?

	No	Yes	If yes, enter brief description and dates.
24. Is treatment result of occupational illness or injury?			
25. Is treatment result of auto accident?			
26. Other accident?			
27. If prosthesis, is this initial placement?			(If no, reason for replacement) — 28. Date of prior placement
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.

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.

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