City of Cuyahoga Falls

Dental Claim Form

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

CompBenefits
PO Box 8236
Chicago, IL 60680-8236

PATIENT COVERAGE INFORMATION

1. Patient name (first, m.i., last)	2. Relationship to employee	3. Sex	4. Patient birthdate	5. If full time student
	❑ self ❑ child ❑ spouse ❑ other _____	m f	MM DD YYYY	School / City

6. Employee/subscriber name and mailing address	7. Employee/subscriber soc. sec. or I.D. #	8. Employee/subscriber birthdate	9. Employer (company) Name and Address	10. Group number
		MM DD YYYY		

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 soc. sec. or I.D. #	14-c. Employee/subscriber birthdate	15. Relationship to beneficiary
		MM DD YYYY	❑ 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 _____

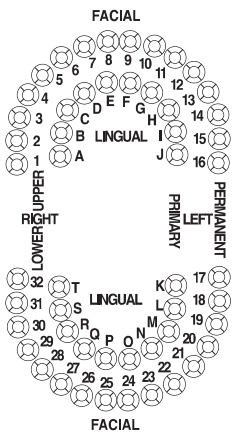
BILLING DENTIST

16. Name of Billing Dentist or Dental Entity	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	25. Is treatment result of auto accident?			
City, State, Zip	26. Other accident?			

18. Dentist Soc. Sec. or T.I.N.	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 Hosp. ECF 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.

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.

CLAIM/CUY