# STANDARD DENTAL CLAIM FORM

## PART 1 - DENTIST

<table>
<thead>
<tr>
<th>P A T I E N T</th>
<th>D E N T I S T</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST NAME</td>
<td>LAST NAME</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>APE.</td>
</tr>
<tr>
<td>CITY</td>
<td>PROV.</td>
</tr>
<tr>
<td>POSTAL CODE</td>
<td>PHONE NO.</td>
</tr>
</tbody>
</table>

**FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATIONS.**

**INSTRUCTIONS FOR CLAIM SUBMISSION**

**BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.**

**IF YOU PLAN IS RESTRICTED TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1 AND 3 COMPLETED TO THE CARRIER’S APPROPRIATE CLAIMS OFFICE.**

**IF YOUR PLAN USES ENVIRONMENTAL / DENTAL/PLANT ADMINISTRATOR, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.**

## PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. **GROUP POLICY/PLAN NO.**
2. **DIVISION/SECTION NO.**
3. **EMPLOYER**
4. **NAME OF INSURING AGENCY OR PLAN**

## PART 3 - PATIENT INFORMATION

1. **PATIENT: RELATIONSHIP TO EMPLOYEE/PLAN MEMBER/SUBSCRIBER**
2. **DATE OF BIRTH**
3. **IF CHILD INDICATE (STUDENT HANDICAPPED)**
4. **IF STUDENT, INDICATE SCHOOL**
5. **DATE OF BIRTH**
6. **NAME OF OTHER INSURING AGENCY OR PLAN**

## PART 4 - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

1. **DATE COVERAGE COMMENCED**
2. **DATE DEPENDENT COVERED**
3. **DATE TERMINATED**
4. **CONTRIBUHOLDER**
5. **AUTHORIZED SIGNATURE**

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**ADDRESS**

**SIGNATURE OF SUBSCRIBER**

**SIGNATURE OF PATIENT (PARENT/GUARDIAN)**

**OFFICE VERIFICATION**

**DATE**

**DEED UBLE**

**DATE**

**PLAN**

**DATE**

**CLAI**

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**TOTAL FEE SUBMITTED**

**FOR CARRIER USE**

<table>
<thead>
<tr>
<th>ALLOWED AMOUNT</th>
<th>INC</th>
<th>%</th>
<th>PATIENT’S SHARE</th>
</tr>
</thead>
</table>

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