**DENTAL CLAIM FORM**

**CARRIER NAME AND ADDRESS**

**Check one:**

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

## PATIENT COVERAGE INFORMATION

1. Patient's 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. number
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)
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. number
14-c. Employee/subscriber birthdate: MM DD YYYY
15. Relationship to patient: ☐ 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

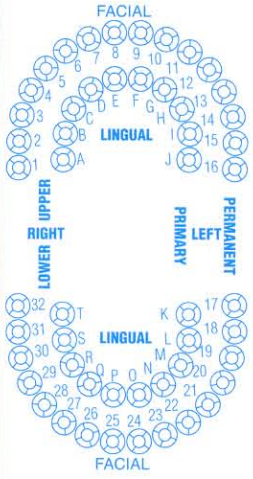
**I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.**

Signed (insured person) Date

## BILLING DENTIST

16. Name of Billing Dentist or Dental Entity: Paul S. Burkey, D.D.S., M.S.
17. Address where payment should be remitted: 290 Center Drive
City, State, Zip: Vernon Hills, IL 60061
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.: 847/367-1640
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. treat. remain.

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 % | |
| | |
| | |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*Form Approved by the Council on Dental Care Program*
AMERICAN DENTAL ASSOCIATION