



STANDARD DENTAL CLAIM FORM

PART 1 DENTIST UNIQUE NO.	PEC. PATIENTS OFFICE ACCOUNT NO. I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS C TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER	
P	SIGNATURE OF SUBSCRIBER	
FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATIONS.	I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PL	
	BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREAT I ACKNOWLEDGE THAT THE TOTAL FEE OF S IS ACCURATE AND HAS BEEN CHARGED TO M SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVER OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.	IE FOR
	SIGNATURE OF PATIENT (PARENT/GUARDIAN)	
	OFFICE VERIFICATION	
DATE OF SERVICE PRO- INTL. DAY MO YR CEDURE TOOTH TOOTH DENTIST'S LABORATOR		
DAY MO. YR. CEDURE 1001H TOOTH DENTIST'S LABORATOR CODE CODE SURFACES FEE CHARGE	TOTAL CHARGES FOR CARRIER USE	
	ALLOWED AMOUNT INC % PATIENT'S SHAR	RE
	CHEQUE NO. DATE	
	DEDUCTIBLE PATIENT PAYS PLAN PAYS	
	DEDUCTIBLE FAILENT FATS FLAN FATS	
THIS IS AN ACCIDATE STATEMENT OF SERVICES DEDECOMED	CLAIM NO.	
IIIIO IO AN AUGUNAIE SIAIEMENI UF SENVICES PENFUNMED	CLAIM NU.	
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE. TOTAL FEE SUBMITTED	CLAIM NU.	
AND THE TOTAL FEE SUBMITTED INSTRUCTIONS FOR CLAIM SUBMISSION		
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