CLAIM FOR DENTAL EXPENSE BENEFITS

☐ Dentist's Pre-Treatment Estimate
☐ Dentist's Statement of Actual Services

P.O. Box 6927
Columbia, SC 29260
(803) 462-0151 / (800) 768-4375
Fax: (803) 870-8012

PART I – TO BE COMPLETED BY THE EMPLOYEE

1. PATIENT NAME *(First, Initial, Last)*	2. Relationship to Employee				3. Sex		4. Patient Birthdate			5. If full-time student:	
	Self	Spouse	Child	Other	M	F	Mo.	Day	Year	School	City

6. Employee/Subscriber Name *(First, Middle, Last)*	7. Employee UMID # *(on front of member's PAI ID card)*		
Spouse's Name	Spouse's Birthdate Month	Day	Year

8. Employee Mailing Address	9. Employer (Company) Name and Address
City State Zip	

10. Group No.	11. Are other family members employed? Yes No If "yes," employee name:				12. Name and address of employer in item 11.
Birthdate:	Mo.	Day	Year	Social Security Number:	

13. Is patient covered by another Dental Plan?	Dental Plan Name	Group Number	Name and Address of Carrier

I have reviewed the following plan. I authorize release of any information relative to this claim to the insurer.	I hereby certify to the above statements.	I hereby authorize payment directly to the below named dentist of the group benefits otherwise payable to me. This authorization is invalid unless the tax ID of the provider is given below.
Signed (Patient or Parent if Minor) ______ Date ______	Employee Signature ______ Date ______	Employee Signature ______ Date ______

PART II – TO BE COMPLETED BY ATTENDING DENTIST

		No	Yes	If yes, enter brief description and dates
14. Dentist Name	22. Is treatment result of occupational illness or injury?			
15. Mailing Address	23. Is treatment result of auto accident? 24. Other accident?			
City State Zip	25. Are any services covered by another plan?			
16. Dentist Soc. Sec. or EIN 17. Dentist License No. 18. Dentist Phone No.	26. If prosthesis, is this initial placement?			If no, reason for replacement:: 27. Date of prior placement:

19. First visit date current series	20. Place of Treatment				21. Radio-graphs or models enclosed?	No	Yes	How many?	28. Treatment for Orthodontics?			If services already commenced: Date of case diagnosis: Date appliances placed: Mos. treatment remaining:
	Office	Home	Hosp	Other								

Indicate Missing Teeth with An "X"

FACIAL, LINGUAL, UPPER, LOWER, RIGHT, LEFT, PRIMARY, PERMANENT — teeth 1–32, A–T

29. 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 of Service Mo.	Day	Yr.	ADA Procedure No.	Fee	For Carrier Use Only
						Total fee actually charged		

I hereby certify that the procedures as indicated by date have been completed.

______________________________ Date__________

* Signed (Dentist)

30. REMARKS FOR UNUSUAL SERVICES