CLAIM FOR DENTAL EXPENSE BENEFITS

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

Planned Administrators Incorporated
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: Self / Spouse / Child / Other	3. Sex: M / F	4. Patient Birthdate: Mo. / Day / Year	5. If full-time student: 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:	

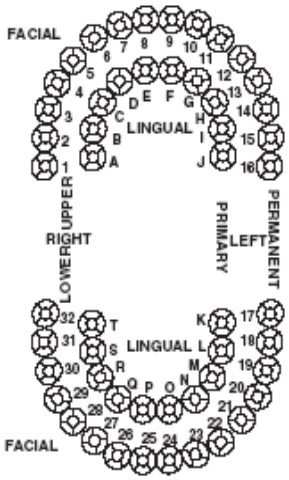
13. Is patient covered by another Dental Plan?	Dental Plan Name	Group Number	Name and Address of Carrier

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: Office / Home / Hosp / Other / 21. Radiographs 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:

Indicate Missing Teeth with An "X"



30. REMARKS FOR UNUSUAL SERVICES

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)