CLAIM FOR DENTAL BENEFITS

File Claims to:
MERITAIN HEALTH
P.O. Box 853921
Richardson, TX 75085-3921

EMPLOYER _____

CHECK ONE: ☐ **DENTISTS PRE-TREATMENT ESTIMATE** ☐ **DENTISTS STATEMENT OF ACTUAL SERVICES**

PATIENT SECTION

1. PATIENT NAME — Last / First / Middle Initial
2. RELATIONSHIP TO EMPLOYEE — ☐ SELF ☐ SPOUSE ☐ CHILD
3. SEX — ☐ M ☐ F
4. PATIENT BIRTHDATE — Month / Day / Year
5. EMPLOYEE NAME — Last / First / Middle Initial
6. EMPLOYEE SOCIAL SECURITY NUMBER
7. EMPLOYEES MARITAL STATUS — ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
8. EMPLOYEE MAILING ADDRESS *(If new address, contact your employer's personnel office to make the appropriate changes.)* — Street Address / City / State / Zip
9. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO — Name / Soc. Sec. No. / RELATIONSHIP ☐ SPOUSE ☐ CHILD
10. NAME AND ADDRESS OF EMPLOYER IN ITEM 9
11. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO — DENTAL PLAN NAME _____ GROUP # _____
NAME AND ADDRESS OF OTHER INSURANCE CARRIER
12. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? ☐ YES ☐ NO
13. IS TREATMENT RESULT OF AUTO ACCIDENT? ☐ YES ☐ NO — OTHER ACCIDENT? ☐ YES ☐ NO
14. ENTER BRIEF DESCRIPTION OF ACCIDENT AND DATES

15. **AUTHORIZATION TO RELEASE INFORMATION** - I hereby authorize any dentist, orthodontist, druggist, or any other Provider (including other insurance companies), Employer or Organization to release any information or view a copy of my records pertaining to the examination, treatment, history, prescriptions or dental expenses to Meritain Health, or its representatives, for the purpose of validating and determining benefits payable in connection with the claim. Furthermore, I understand that any person who, with intent to defraud or knowing that he/she is facilitating a fraud, submits an application for coverages or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud.

Patient Signature (or parent if minor) _____ Date _____

By my signature, I acknowledge that payment of this claim is subject to the Plan's rights of subrogation and reimbursement, and to the coordination of benefits with any other coverage that the patient may have. Furthermore, I certify that the foregoing information is true and correct.

16. **PAYMENT AUTHORIZATION** - I HEREBY AUTHORIZE PAYMENT FOR THESE BENEFITS BE SENT DIRECTLY TO (CHECK ONE):

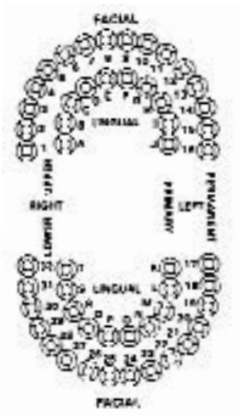
☐ PROVIDER OF SERVICE ☐ EMPLOYEE (attach proof of payment or have provider mark this form *paid in full*)

Patient Signature (or parent if minor) _____ Date _____

DENTIST

17. DENTIST NAME
22. FIRST VISIT DATE CURRENT SERIES
23. PLACE OF TREATMENT ☐ OFFICE ☐ HOSP. ☐ ECF ☐ OTHER
24. RADIOGRAPHS OR MODELS ENCLOSED? ☐ YES ☐ NO
25. HOW MANY?
18. MAILING ADDRESS
26. ARE ANY SERVICES COVERED BY ANOTHER PLAN? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE DETAILS
CITY, STATE, ZIP
27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO
(IF NO, REASON FOR REPLACEMENT)
28. DATE OF PRIOR REPLACEMENT
19. DENTIST SOC. SEC. NO. T.I.N.
20. DENTIST LICENSE NO.
21. DENTIST PHONE NO.
29. IS TREATMENT FOR ORTHODONTICS? ☐ YES ☐ NO
IF SERVICES ALREADY COMMENCED:
DATE APPLIANCES PLACED:
MOS. TREATMENT REMAINING:

IDENTIFY MISSING TEETH WITH X"



Root Canal Dates
Open _____ Close _____

Crown Dates
Prep _____ Cement _____

Prosthesis Dates
Impress _____ Insert _____

30. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 31 - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO.	DAY	YEAR	ADA PROCEDURE NUMBER	FEE		FOR ADMINISTRATIVE USE ONLY

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

_____ SIGNED (DENTIST) _____ DATE

TOTAL FEE CHARGED

dental3/02