# Dental Claim Form

P.O. Box 232 Grand Rapids, MI 49501-0232

PriorityHealth®

CHECK ONE
- ❑ DENTIST'S PRE-TREATMENT ESTIMATE
- ❑ DENTIST'S STATEMENT OF ACTUAL SERVICES

MAIL THIS FORM TO: **PRIORITY HEALTH**
**P.O. BOX 232**
**GRAND RAPIDS, MI 49501-0232**

## SECTION 1 - EMPLOYEE INFORMATION (COMPLETED BY EMPLOYEE)

1. Patient Name

2. Relationship to Employee: self ❑ spouse ❑ son ❑ daughter ❑ other ❑

3. Sex: M F

4. Patient Birthdate: MO DAY YEAR

5. If full time student: SCHOOL CITY

6. Employee Name: Last First MI

7. Employee Contract Number

8. Employee Birthdate: MO DAY YEAR

9. Employee Mailing Address

10. Employer Name

11. City, State, Zip

12. Group Number

13. Are other family members employed? ❑ Yes ❑ No
If yes, Employee Name Soc. Sec. No.

14. Name and Address of Employer in Item 13

15. Is patient covered by another dental plan? ❑ Yes ❑ No If yes, Dental Plan Name Group No.

Name and Address of Carrier

## SECTION 2 - AUTHORIZATION

AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to Priority Health for any dental observation, treatment, services or benefits rendered or payable to me or on my behalf. A photostat of this authorization shall be valid as the original.

SIGNED (PATIENT OR PARENT IF MINOR) DATE

ASSIGNMENT - I hereby assign benefits to the attending dentist (Not necessary if plan provides for automatic payment)

EMPLOYEE'S SIGNATURE _____ DATE _____

## SECTION 3 - TO BE COMPLETED BY ATTENDING DENTIST

16. Dentist Name

17. Mailing Address

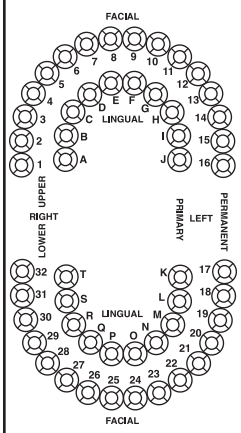
City, State, Zip

18. Dentist Soc. Sec. or TIN (required for all assignments) 19. Dentist License NO. 20. Dentist Phone No.

21. First Visit Date current series 22. Place of treatment 23. Radiographs of models No Yes How Many

| | NO | YES | |
|---|---|---|---|
| 24. Is treatment result of occupational illness or injury? | | | If yes, enter brief description and dates |
| 25. Is treatment result of auto accident? 26. Or other accident? | | | |
| 27. Are there any services covered by another plan? | | | If yes, name of other plan |
| 28. If Prosthesis, is this initial placement? | | | If no, reason for replacement 29. Date of prior placement |
| 30. Is treatment for orthodontics | | | If services already commenced, enter Date Appliance Placed Mos. Treatment Remaining |

Identify Missing Teeth with X




32. Remarks for unusual services

31. Examination and treatment plan. List in order from tooth No. 1 through tooth No. 32. Use charting system.

| Tooth # or Letter | Surface | DESCRIPTION OF SERVICE Including X Rays, Prophylaxis, Materials used, Etc. Line No. | Date Service Performed MO Day Year | Procedure Number | Fee | For Administrative Use Only | EXPL CODE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

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

SIGNED (DENTIST) DATE

IF INSURED HAS MADE PAYMENT, PLEASE INDICATE AMOUNT $ _____

| | |
|---|---|
| TOTAL FEE CHARGED | |
| MAX ALLOWANCE | |
| DEDUCTIBLE | |
| PLAN % | |
| PLAN PAYS | |
| PATIENT PAYS | |

5064A - MB610 (5/09)

Please Note: Pretreatment Review is not a guarantee of benefits payable.
This estimate advises you in advance of the amount of benefits payable if the described procedures are performed during a period of the patient's eligibility.