

## STANDARD DENTAL

**CLAIM FORM** Please print



PART 1 DENTIST														UNIQUE NO.			S	SPEC. PATIEN			IT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE
Р	LAST I											GIVEN	NAME			PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.						
A T·	ADDRI	SS											APT.									
E																						
N T												POSTAL	CODE	S PHONE NO. SIGNATURE OF SUBSCR								SIGNATURE OF SUBSCRIBER
										AL INFORM	IATION	I, DIAGI	NOSIS,	I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN								
PROCEDURES, OR SPECIAL CONSIDERATION.													BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.									
														I AL	лтно	RIZE F	RELEAS	SE O	F TH	IE INFO	ORMATION CONTAINED IN	THIS CLAIM FORM TO MY INSURING
																					O AUTHORIZE THE COMMUN BED IN THIS FORM TO THE N	IICATION OF INFORMATION RELATED TO IAMED DENTIST.
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	DATE OF SERVICE			PROCEDURE CODE			E	INTL.TOOTH CODE		U TOOTH SURFACES		DENTIST'S FEE		LABORATORY CHARGE			TOTAL CHARGES					STRUCTIONS
																					the plan member. We	may exchange personal information
																						n member and a person acting on his cessary to confirm eligibility and to
																					mutually manage the claim 1. Have your dentist com	
																				_	2. Employee completes I	Parts 2 and 3.
															_					_		be paid directly to the dentist, sign the Part 1 above. Assignment of benefits
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