

STATEMENT OF CLAIM — DENTAL CARE

- 1 Employees must complete and sign Part A and Dentist must complete and sign Part B.
 2. Attach bills for covered expenses to this form. Bills must show: patient's name, date, nature of illness, type of service and amount charged.
- PLEASE COMPLETE IN FULL.**



PO Box 2639 • Lilburn, GA 30048 • 770-451-7550

PART A — PATIENT INFORMATION			
Patient's Name (first, MI, last)		Employee's Name (first, MI, last)	
Sex <input type="radio"/> M <input type="radio"/> F	Date of Birth	Relationship to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	Employer's Name and Address (street, city, state and zip code)
Home Address (street, city, state and zip code)			
If Patient is covered by other dental plan: Plan Name		Is treatment related to: Patient's Employment? <input type="radio"/> Yes <input type="radio"/> No An Auto Accident? <input type="radio"/> Yes <input type="radio"/> No Other Accident? <input type="radio"/> Yes <input type="radio"/> No	If "Yes", Description, Date & Time
Name of Policyholder	Policy Number		
<p>I have reviewed the following treatment plan and authorized the release of any information relating to this claim. By signing below I certify that the above information is correct. TPA of Georgia may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photocopy of this authorization is as valid as the original. I hereby direct benefits payable to the attending dentist.</p>			
Employee's Signature		Spouse's Signature (for dependent claims only)	Date

PART B — DENTIST/TREATMENT INFORMATION												
Dentist Name (first, MI, last)			First Visit Date (Current Series)									
Address (street, city, ST, zip)			Place of Treatment: <input type="radio"/> Office <input type="radio"/> Hospital <input type="radio"/> ECF <input type="radio"/> Other									
			Radiographs or models enclosed? <input type="radio"/> Yes <input type="radio"/> No How Many?									
Dentist SSN or TIN	Dentist License Number	Phone Number	First Visit Date (Current Series)									
If prosthesis crown or inlay, is this initial placement?			<input type="radio"/> Yes <input type="radio"/> No		If "No, give reason for replacement and date of prior placement							
Is this treatment for orthodontics?			<input type="radio"/> Yes <input type="radio"/> No		If "Yes", give date appliances placed and months treatment remaining							
Identify Missing Teeth With "X"	Examination and Treatment Plan (list in order from Tooth 1 - 32 using charting system shown)					ADMINISTRATIVE USE ONLY						
	Tooth No/Ltr	Surface	Description of Services (including X-rays, prophylaxis, materials used,	Date Svcs Performed	Procedure Number	Fee						
Remarks for unusual services:												
			<input type="radio"/> Pretreatment Estimate <input type="radio"/> Statement of Actual Services		Total Fees Charged							
I hereby certify that the procedures as indicated by date have been completed and that fees submitted are the actual fees I have charged <i>this patient</i> and intend to accept for these procedures.												
Dentist's Signature										Date		