

**MedCost Benefit Services**

P.O. Box 25987  
 Winston-Salem, NC 27114-5987  
 (336) 774-4400 Fax (336) 774-4420  
 1-800-795-1023



**STATEMENT OF DENTAL CLAIM**

GROUP # \_\_\_\_\_

**EMPLOYEE SECTION**

1. PATIENT'S NAME		RELATION TO EMPLOYEE: SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	PATIENT'S BIRTHDATE / /	IF FULL-TIME STUDENT: SCHOOL
2. EMPLOYEE NAME (LAST, FIRST, MI)				MEMBER ID	BIRTHDATE / /
3. EMPLOYEE'S ADDRESS (CHECK HERE IF NEW ADDRESS <input type="checkbox"/> )		CITY		STATE	ZIP
4. IS SPOUSE OR PATIENT EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME & ADDRESS OF EMPLOYER			MEMBER ID	SPOUSE'S BIRTHDATE / /
5. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", PLEASE GIVE: CARRIER NAME _____ ADDRESS _____ PLAN NO. _____					
6. I AUTHORIZE PAYMENT TO THE DENTIST NAMED BELOW OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME SIGNATURE OF EMPLOYEE _____ DATE _____					
7. I authorize any provider, insurer, or other organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable. <b>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.</b> SIGNATURE OF EMPLOYEE _____ SIGNATURE OF PATIENT IF OTHER THAN MINOR CHILD _____ DATE _____					

WOULD YOU LIKE THE BALANCE OF THIS CLAIM SUBMITTED TO YOUR FLEXIBLE BENEFIT PLAN FOR CONSIDERATION? YES  NO

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**DENTIST SECTION**

1. SOCIAL SECURITY NO. OR TIN	LICENSE NO.	PHONE NO.	2. DENTIST'S NAME & COMPLETE ADDRESS
3. FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT <input type="checkbox"/> OFFICE <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ECF <input type="checkbox"/> OTHER	X-RAYS ENCLOSED? IF "YES", HOW MANY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
4. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? IF "YES", ENTER BRIEF DESCRIPTION AND DATES. YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. IS TREATMENT A RESULT OF AUTO ACCIDENT? OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		6. ARE SERVICES COVERED BY ANOTHER PLAN? IF "YES", GIVE NAME OF PLAN. YES <input type="checkbox"/> NO <input type="checkbox"/>	
7. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF "NO", GIVE REASON FOR REPLACEMENT. GIVE DATE OF PRIOR PLACEMENT. YES <input type="checkbox"/> NO <input type="checkbox"/>			
8. IS TREATMENT FOR ORTHODONTICS? IF "YES", AND SERVICES ALREADY COMMENCED, GIVE DATE APPLIANCES PLACED. GIVE MONTHS OF TREATMENT REMAINING. YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. EXAMINATION AND TREATMENT PLAN: LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 AND USE THE CHARTING SYSTEM SHOWN. CHECK ONE: <input type="checkbox"/> DENTIST'S PRE-TREATMENT ESTIMATE (DATE) _____ <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES			

10. Indicate missing teeth with an "x"	Tooth No. or letter	Surface (M, O, D, B, L, LA, I)	Description of service (including xrays, prophylaxis, material used, etc.)	Date service completed Mo. Day. Yr.	Procedure Number	Fee

10. REMARKS FOR UNUSUAL SERVICE			
I CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.			<b>Total Fee</b>
Dentist's signature _____ Date _____			