Dental / Vision Claim Form

Subscriber Information:

1. Name, Address, City, State, Zip Code

_____

_____

_____

2. Date of Birth (MM/DD/CCYY)_____

Patient Information:

4. Relationship to Primary Subscriber _____

5. Name(Last, First, Middle Initial, Suffix) Address, City, State, Zip Code

_____

_____

_____

6. Date of Birth (MM/DD/CCYY)_____

7. Dental or Vision coverage (circle one) 8. Date of Service:_____

9. Service Provided:_____

_____

_____

10. Claim Amount:_____

Provider Information:

11. Name/ Address of Provider_____

_____

_____

12. Phone:_____ **13. Provider IIN/SSN:**_____

14. License #_____**15. Patient Acct #:**_____

Authorizations

16. I have been informed of the treatment plan and associated fees. I have paid in full all charges pertaining to the above claim. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____

Patient/ Guardian Signature **Date**

17. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entry.

X_____

Insured Signature **Date**