Planned Administrators Incorporated

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Claim for Dental Expense Benefits

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER
3. SEX: M | F
4. PATIENT BIRTHDATE: MO | DAY | YEAR
5. IF FULL TIME STUDENT: SCHOOL | CITY

6. EMPLOYEE NAME: First | Middle | Last
7. EMPLOYEE SOC. SEC. NO.
SPOUSE'S NAME
SPOUSE'S BIRTHDATE: Mo. | Day | Yr.

8. EMPLOYEE MAILING ADDRESS

CITY, STATE, ZIP

10. EMPLOYER (COMPANY) NAME AND ADDRESS

11. GROUP NO.

13. ARE OTHER FAMILY MEMBERS EMPLOYED? YES NO
Employee Name | Birthdate Mo. | Da. | Yr. | Soc. Sec. No.

14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? | DENTAL PLAN NAME | GROUP NO.

NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Signed (Patient or Parent if Minor) | Date

I HEREBY CERTIFY TO THE ABOVE STATEMENTS.

Employee Signature | Date

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP BENEFITS OTHERWISE PAYABLE TO ME. THIS AUTHORIZATION IS INVALID UNLESS THE TAX I.D. OF THE PROVIDER IS GIVEN BELOW.

Employee Signature | Date

16. DENTIST NAME

17. MAILING ADDRESS

CITY, STATE, ZIP

18. DENTIST SOC. SEC. OR EIN | 19. DENTIST LICENSE NO. | 20. DENTIST PHONE NO.

21. FIRST VISIT DATE CURRENT SERIES | 22. PLACE OF TREATMENT: Office | Home | Hos. | Other

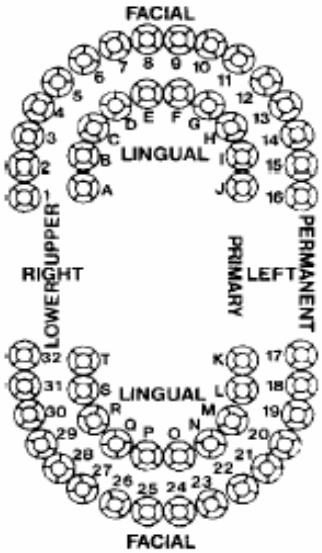
23. RADIOGRAPHS OR MODELS ENCLOSED? YES | NO | HOW MANY?

	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. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
30. TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED. ENTER: DATE APPLIANCES PLACED; MOS. TREATMENT REMAINING

DENTIST'S
- Pre-Treatment Estimate
- Statement of Actual Services

31. Examination and Treatment Plan—List in Order Tooth No. 1 through Tooth No. 32
Use Charting System Shown

Identify missing teeth with "x"



Tooth # or letter	Surfaces	DESCRIPTION OF SERVICE (including X-Rays, Prophylaxis Materials Used, Etc.)	Date Service Performed Mo.	Da	Yr.	ADA Procedure Number	Fee	For Carrier Use Only

I hereby certify that the procedures as indicated by date have been completed.

Total Fee Actually Charged

* Signed (Dentist) | Date

32. REMARKS FOR UNUSUAL SERVICES