

Dental Claim Form



Complete and send to:
 Meritain Health
 P.O. Box 27267
 Minneapolis, MN 55427-0267
Fax: 952-593-3727

IMPORTANT: Please have your dentist or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

EMPLOYEE INFORMATION

Name (last, first, initial)		Sex	Employer Name	
Home Address		Identification Number	Birthdate	Group Number
City	State	ZIP Code	Work Telephone ()	Home Telephone ()

PATIENT INFORMATION

The Patient is: THE EMPLOYEE (go to No. 3) EMPLOYEE'S SPOUSE (complete spouse information) EMPLOYEE'S CHILD (complete spouse and child information)

Spouse's Name (last, first, initial)		Sex	Child's Name (last, first, initial)		Sex
Spouse's Birthdate	Spouse's Social Security Number		Child's Birthdate	Child's Social Security Number	
Spouse's Employer			If child is over age 19 and full-time student, complete: Name of School:		
Spouse's Employer's Address			School Address		

OTHER COVERAGE

YES (then complete) NO (go to No. 4)

Name of Other Health Insurance Carrier or Plan		Address		City		State	ZIP Code
Other Insurance Carrier's or Plan's Telephone No.	Type of Coverage <input type="checkbox"/> GROUP <input type="checkbox"/> INDIVIDUAL		Group Number		Contract or Policy Number		
Spouse's Employer			If child is over age 19 and full-time student, complete: Name of School:				
Spouse's Employer's Address			School Address				

ABOUT THIS CLAIM

INJURY ILLNESS

Date and time of accident: _____ Describe injury, when and how it happened or nature of illness: _____

Was injury the result of auto accident? YES NO

If auto insurance involved, please provide: Policy No. _____ Name of Insurance Company _____ Address (City, State, ZIP Code) _____

Work related injury? YES NO **If injury is work related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.**

EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

Signature _____ Date _____

ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)

I authorize payment of benefits directly to the dentist or supplier of services listed here.

Provider to be paid _____ Employee's Signature _____

Provider's Tax ID No. or Social Security No. _____ Date _____



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PHYSICIAN OR SUPPLIER STATEMENT

A	Patient Name (last, first, middle initial)		Birthdate	
	Address			
B	Dentist's Name			
	Address			
	City	State	ZIP Code	Telephone ()
	Provider's Tax ID No. or SSN: <input type="text"/>		Dentist's License No.:	

C	Is treatment a result of injury arising from patient's employment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, description and date:	
	Is treatment the result of an auto accident?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, description and date:	
	Are any services covered by another plan?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, name of other plan:	
	If prosthesis, is this an initial placement?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, reason for placement and date of previous placement:	
	Is treatment for orthodontics?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date appliances placed:	Mo. of treatment remaining:
D	Is this claim for a pre-treatment estimate?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, are x-rays enclosed?	<input type="checkbox"/> YES <input type="checkbox"/> NO

EXAMINATION AND TREATMENT RECORD

E			Tooth No. or Letter	Surface	Procedure Number (ADA)	Description of Services (include x-rays, prophylaxis, materials used, etc.)	Date of Service	Charges

F	I hereby certify that the above procedures have been completed on the date indicated.	
	Dentist's Signature _____	Date _____

STATUS AND BENEFIT INFORMATION:
1-800-925-2272



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