DENTAL CLAIM FORM

PATIENT INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. PATIENT'S SOCIAL SECURITY #:
4. PATIENT'S ADDRESS *(if different from employee)*	5. PATIENT'S SEX ☐ MALE ☐ FEMALE	6. TELEPHONE NUMBER:
7. EMPLOYEE'S NAME *(First name, middle initial, last name)*	8. EMPLOYEE'S SOCIAL SECURITY #:	9. EMPLOYEE'S ADDRESS: *(City, State, and Zip Code)*
10. PATIENT'S RELATIONSHIP TO EMPLOYEE:	11. FULL-TIME STUDENT? ☐ YES ☐ NO	12. ANY OTHER DENTAL COVERAGE? IF SO, WITH WHOM?
13. I AUTHORIZE PAYMENT TO PROVIDER: ☐ YES ☐ NO	14. EMPLOYER NAME:	**DENTE*MAX*** PREFERRED DENTAL NETWORK ☐ YES ☐ NO

17. To all dentists, dental health professionals, all hospitals and other health care institutions: You are authorized to provide Professional Benefits Services, Inc. and any independent claim administrators and consulting health professionals and utilization review organizations with whom PBS has contracted, information concerning health care, advice, treatment or supplies provided the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.

PBS 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 photographic copy of this authorization is as valid as the original.

SIGNED (Employee or Authorized Person) X _____ DATE _____

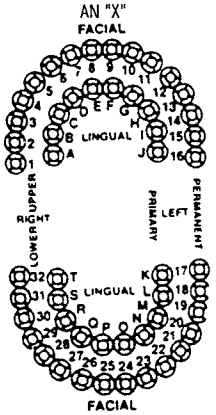
DENTIST'S INFORMATION

1. DENTIST NAME:	9. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES:
2. MAILING ADDRESS: IS THIS A NEW ADDRESS? ☐ YES ☐ NO	10. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	11. OTHER ACCIDENT?			
CITY, STATE, and ZIP CODE:	12. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			

3. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSE'S. YOU ARE REQUIRED UNDER AUTHORITIY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER.:	4. DENTIST LICENSE NO.:	13. IF PROTHESIS, IS THIS INITIAL PLACEMENT?		IF NO, REASON FOR REPLACEMENT:	14. DATE OF PRIOR REPLACEMENT?
	5. DENTIST TELEPHONE NO.:				

6. FIRST VISIT DATE CURRENT SERIES:	7. PLACE OF TREATMENT: ☐ OFFICE ☐ HOSPITAL ☐ ECF ☐ OTHER	8. RADIOGRAPHS OR MODELS ENCLOSED? ☐YES ☐NO HOW MANY?____	15. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED_____ MONTHS TREATMENT REMAINING_____

IDENTIFY MISSING TEETH WITH AN "X"



16. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH #1THROUGH TOOTH #32. USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	17. IF PREVIOUSLY EXTRACTED GIVE DATE EXTRACTED BELOW	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC...) LINE NO.	DATE SERVICE PERFORMED MO. DAY YR.	PROCEDURE NUMBER	FEE
			1			
			2			
			3			
			4			
			5			
			6			
			7			
			8			
			9			
			10			
			11			
			12			

18. I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES. I HAVE CHARGED THIS PATIENT AND INTEND TO ACCEPT PAYMENT FOR THOSE PROCEDURES.

X _____ _____
SIGNED (DENTIST) DATE

TOTAL FEE CHARGED		
AMOUNT PAID		

MAIL TO:

Professional Benefits Services Inc.
2959 Lucerne, SE, Suite 205
Grand Rapids, Michigan 49546

Telephone:
1-616-285-2480 or 1-800-732-3412

PBS PROFESSIONAL BENEFITS SERVICES