

**Dental Claim Form**

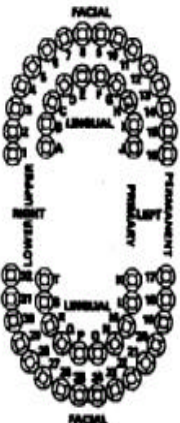
Check one: <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services	Carrier name and address: <b>Hewitt, Coleman &amp; Associates, Inc.</b> <b>Post Office Box 6708</b> <b>Greenville, South Carolina 29606</b>
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**Patient Coverage Information**

1. Patient name First M.I. Last	2. Relationship to employee <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other_____	3. Sex M   F	4. Patient Birthdate MM   DD   YYYY	5. If full-time student: School: City:
6. Employee/subscriber name and mailing address:	7. Employee/Subscriber Soc. Sec. Or I.D. Number	8. Employee/Subscriber Birthdate MM   DD   YYYY		9. Employer (company) name and address:
10. Group Number				
11. Is patient covered by another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient covered by another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete 12-a	12-a. Name and address of carrier(s)	12-b. Group Number(s)	13. Name and address of other employer(s)	
14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/Subscriber Soc. Sec. Or I.D. Number	14-c. Employee/Subscriber Birthdate MM   DD   YYYY	15. Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other_____	
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment		I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.		
Signed (Patient, or parent if minor) _____ Date _____		Signed (Insured Person) _____ Date _____		

**BILLING DENTIST**

16. Name of Billing Dentist or Dental Entity	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates.
17. Address where payment should be remitted	25. Is treatment result of auto accident?			
City, State, Zip	18. Dentist's Phone Number	26. Other accident?		
19. Dentist Soc. Sec. Or T.I.N.	20. Dentist's License No.	27. If prosthesis, is this initial placement?		If no, reason for replacement
21. First visit date current series	22. Placement of treatment Office   Hosp   ECF   Other	23. Radiographs or models enclosed? Yes   No   How Many	28. Date of Prior Placement	Mos. treatment remaining?
		29. Is treatment for orthodontics?		If services already commenced enter?
				Date appliances placed?

Identify missing teeth with "X"  	30. Examination and treatment plan - List in order from Tooth No. 1 through Tooth No. 32 - Using chart system shown.						For Administrative Use Only
	Tooth # or Letter	Surface	Description of Service (Including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo   Day   Yr	Procedure Number	Fee	

31. Remarks for unusual services			

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charges and intend to collect for those procedures.	Total Fee Charged	
Signed (Treating Dentist) _____ License _____ Date _____		