CLAIM FOR DENTAL EXPENSE BENEFITS

- **Submit x-rays with:**
  - treatments involving gold restoration, crowns root canals, or bridgework.
    X-RAYS MAY BE REQUESTED FOR OTHER SERVICES

Any person who knowingly and with intent to injure, defraud, or deceive any Insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree

MAIL TO:
CLAIMS DEPARTMENT
P.O. BOX 925309
HOUSTON, TX 77292-2728

TO BE COMPLETED BY DENTIST

PART 1

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 SOCIAL SECURITY NO.	8. EMPLOYEE POLICY #	9. GROUP NUMBER IF KNOWN

10. EMPLOYEE MAILING ADDRESS	CITY, STATE	ZIP	11. EMPLOYER (COMPANY) NAME AND ADDRESS	CITY, STATE	ZIP

12. ARE OTHER FAMILY MEMBERS EMPLOYED? ❒ NO ❒ YES
EMPLOYEE NAME / SOC. SEC. NO.

13. NAME AND ADDRESS OF EMPLOYER IN ITEM 12.

14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? / DENTAL PLAN NAME / UNION LOCAL / GROUP NO. / NAME AND ADDRESS OF CARRIER
❒ NO ❒ YES If yes, give

15a. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

15b. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

Part 2

PATIENT'S SIGNATURE (PARENT IF A MINOR) / DATE

EMPLOYEE'S SIGNATURE / DATE

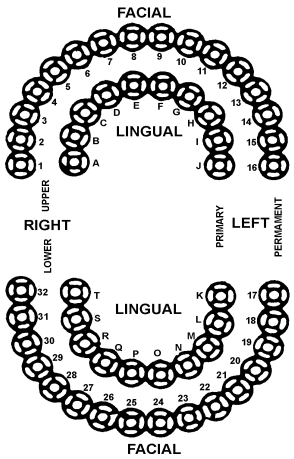
16. DENTIST NAME: FIRST / MIDDLE / LAST	17. MAILING ADDRESS	CITY, STATE	ZIP

18. DENTIST SOC. SEC. OR TIN	19. DENTIST LICENSE NO.	20. DENTIST PHONE NO.

21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT: OFFICE / HOSP. / ECF / OTHER	23. RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	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. IS TREATMENT FOR ORTHODONTICS			IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

31. DENTIST – CHECK ONE
❒ PRETREATMENT ESTIMATE
❒ STATEMENT OF ACTUAL SERVICES



32. EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32
USE CHARTING SYSTEM SHOWN

FOR HOME OFFICE USE ONLY

Tooth No. or Ltr.	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis Materials Used, etc.)	Date Service Performed: Mo.	Day	Yr.	Procedure Number (see over)	FEE		❒ SCHEDULE ❒ OTHER	

DENTAL UNIT USE
Employee Eligible Date _____
Employee Effective Date _____
Termination Date _____
Verified By _____
Date _____

THESE BENEFITS WILL, SUBJECT TO POLICY PROVISIONS, BE PAYABLE IF THE DESCRIBED PROCEDURES ARE PERFORMED WHILE THE PATIENT IS INSURED WITH FIRST UNUM INSURANCE COMPANY

TOTAL FEE ACTUALLY CHARGED			
DEDUCTBLE			
PATIENT PAYS			
INSURANCE WILL PAY			

Part 3

TO BE COMPLETED BY DENTIST

I HERBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE ABOVE NAMED PATIENT ON THE DATES INDICATED

DENTIST SIGNATURE _____ DATE _____

MANHATTAN INSURANCE GROUP