HealthComp

Dental Claim Form

Check one:

☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

You can now complete this form electronically on HCOnline at: https://hconline.healthcomp.com/health/formviewer
Instructions: 1. Click the link above to login/sign up 2. Click "Forms" 3. Click "Dental"

PATIENT COVERAGE

First	MI	Last	☐ self ☐ spouse ☐ domestic partner ☐ child ☐ other_____	☐ male ☐ female	MM DD YYYY	School	City

6. Employee /subscriber name and mailing address	7. Employee Soc. sec. or I.D. number	8. Employee birthdate MM DD YYYY	9. Employer name and address	10. Group number

11. Is patient covered by another dental plan? ☐ yes ☐ no If yes complete 12-a thru 15. Is patient covered by a medical plan? ☐ yes ☐ no	12-a Name and address of carrier(s)	12-b Group no(s)	13. Name and address of other employer(s)

14.-a Employee name (if different than patient's)	14-b Employee Soc. sec. or I.D. number	14-c Employee birthdate MM DD YYYY	15. Relationship to patient ☐ self ☐ parent ☐ domestic partner ☐ spouse ☐ 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.

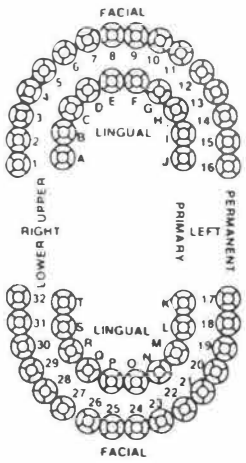
Signed (Patient or parent if minor) _____ Date _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

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	26. Other accident?			
18. 19. 20.	27. If prosthesis, is this initial placement?			(If no, reason for replacement) 28. Date of prior placement
21. First visit date current series / 22. Place of treatment: Office Hosp ECF Other / 23. Radiographs or models enclosed? No Yes How many?	29. Is treatment for orthodontics?			If services already Commenced enter / Date appliances placed / Mos. treatment remaining



30. Examination and treatment plan – List in order from tooth no 1 through tooth no 32 – Use charting system shown

Tooth # or letter	Surface	Description of service (Including x-rays, prophylaxis, materials used, etc.)	Date of Service Performed Mo Day Year	Procedure Number	Fee	For administrative use only

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 charged and intend to collect for those procedures.

Signed (Treating Dentist) _____ License Number _____ Date _____

Total Fee Charged	
Max Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

Need to mail or fax? Submit to: P.O. BOX 45018, FRESNO, CA 93718-5018
FAX (559) 499-2464