# Dental Claim Form

**PLEASE COMPLETE ONE CLAIM FORM PER PATIENT**

| | | | |
|---|---|---|---|
| 1. Complete all questions. | A. Employer Information | Name of Your Employer | Group number as shown on your ID Card |
| | B. Employee Information | Last Name First Name MI | Employee's Social Security Number |
| | | Home Address | Employee's Birth Date<br>Month Day YR |
| | | City State Zip | Marital Status: Single ☐ Married ☐ Divorced ☐ |
| | C. Patient Information. | Last Name First Name MI | Relationship to Employee<br>Self ☐ Spouse ☐ Child ☐ |
| | | Patient's Birth Date<br>Month Day YR | If over 19, is child a full-time student? Yes ☐ No ☐<br>If yes, School attended: |
| | | Is Patient employed? Yes ☐ No ☐<br>If Yes, Name of Employer: | Is Spouse employed? Yes ☐ No ☐<br>If Yes, Name of Employer: |
| | | Does Employer offer Group Dental Plan? Yes ☐ No ☐ | Does Employer offer Group Dental Plan? Yes ☐ No ☐ |
| 2. Complete the sections which apply to your claim. | D. Complete if Patient is covered under any other dental health plan. | Other Group Plan Name | Identification / Policy Number |
| | | Insurance Company Name and Address | |
| | | City State Zip | |
| | E. Complete if services are the result of an accident. | Is claim due to an accident? Yes ☐ No ☐ | If "yes," where did the accident occur? / Date of accident<br>Month Day YR |
| | | Describe Accident | Is this claim the result of a work-related illness or injury? Yes ☐ No ☐ |
| 3. Assignment of Benefits | F. Complete only if you wish payment to be made directly to the dentist. | Name of Dentist | |
| | | City State Zip | |
| | | Phone No.<br>( ) | Provider's I.D. No. |
| | | Employee's Signature Authorizing Assignment of Benefits | Date<br>Month Day YR |
| 4. Must be signed and dated by the Employee. | G. Read and complete authorization to release medical and insurance information. | To any physician, medical practitioner, hospital, clinic or other medically-related facility or provider of medical services or supplies, and any employer, group policyholder, or contract holder or insurer, I authorize you to release to TRISTAR Benefit Administrators, Inc. or to its representatives any and all information you may have about the mental and physical history, condition and treatment, and insurance coverage for the Patient named in Section C above.<br><br>I understand the information obtained by TRISTAR Benefit Administrators, Inc. will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by TRISTAR Benefit Administrators, Inc. to any person or organization EXCEPT to reinsuring companies, Group Policyholder, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required or as I may further authorize. For the purpose of disclosing information, I understand that this authorization is valid for a period of one year. I know that I may request a copy of this authorization. If this authorization is given in connection with a claim for health benefit, disability or life insurance benefits, I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original. | |
| | | Employee's Signature | Date<br>Month Day YR |

**DENTIST MUST COMPLETE THE REVERSE SIDE.**

Please send the completed claim form and appropriate statements to:

TRISTAR Benefit Administrators
P.O. Box 65887
West Des Moines, IA 50265

# ATTENDING DENTIST'S STATEMENT

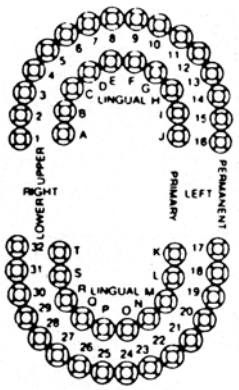
CHECK ONE

☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

| DENTIST NAME | | YES | NO | IF YES ENTER BRIEF DESCRIPTION AND DATES |
|---|---|---|---|---|
| | IS TREATMENT THE RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | | | |
| MAILING ADDRESS | IS TREATMENT RESULT OF AN AUTO ACCIDENT? | | | |
| | OTHER ACCIDENT? | | | |
| CITY STATE ZIP | ARE ANY SERVICES COVERED BY ANOTHER PLAN? | | | |
| DENTIST SOC. SEC/ OR T.I.N. DENTIST LICENSE NO. DENTIST PHONE NO. | IF PROSTHESIS, IS THIS INITIAL PLACEMENT? | | | (IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR REPLACEMENT |
| FIRST VISIT DATE CURRENT SERIES PLACE OF TREATMENT: OFFICE / HOSPITAL / EC F / OTHER — RADIOGRAPHS OR MODELS ENCLOSED? NO / YES / IF YES, HOW MANY? | IS TREATMENT FOR ORTHODONTICS? | | | IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED — MONTHS OF TREATMENT REMAINING |

IDENTIFY MISSING TEETH WITH "X"

FACIAL




FACIAL

32 REMARKS FOR UNUSUAL SERVICES

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

| TOOTH NUMBER OR LETTER | SURFACE | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) | DATE SERVICE PERFORMED MO | DA Y | YR | ADA PROCEDURE CODE | FEE | | FOR ADMINISTRATIVE USE ONLY |
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I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

SIGNED (DENTIST) DATE

| | | | |
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| TOTAL FEE CHARGED | $ | | |
| MAX ALLOWABLE | $ | | |
| DEDUCTIBLE | $ | | |
| CARRIER % | % | | |
| CARRIER PAYS | $ | | |
| PATIENT PAYS | $ | | |


TRISTAR Benefit Administrators
P.O. Box 65887
West Des Moines, IA 50265
Phone: 800-456-4584 Fax 515-453-8210