GROUP DENTAL CLAIM FORM

SUBMIT CLAIMS TO:

ASSURECARE®
Assured Access Health Systems Management
13700 Watertower Circle, Suite D
Plymouth, MN 55441
Phone: (800) 328-0927 Fax: (763) 383-4880

Check one: ☐ DENTISTS PRE-TREATMENT ESTIMATE ☐ DENTISTS STATEMENT OF ACTUAL SERVICES

PART A - TO BE COMPLETED BY EMPLOYEE

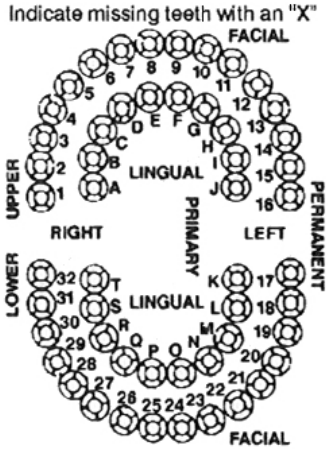
1) EMPLOYEES NAME (Last, First, Middle)			2) EMPLOYEES SOCIAL SECURITY NUMBER
3) EMPLOYEES ADDRESS	CITY	STATE	ZIP CODE
4) PATIENTS NAME (If a Dependent)	5) RELATIONSHIP TO EMPLOYEE		6) BIRTH DATE
7) PATIENTS SOCIAL SECURITY NUMBER	8) EMPLOYERS NAME		

PART B - TO BE COMPLETED BY DENTIST

1) DENTISTS NAME	10) IS TREATMENT THE RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	YES ☐	NO ☐	IF YES, ENTER BRIEF DESCRIPTION AND DATES:	
2) MAILING ADDRESS	11) IS TREATMENT RESULT OF AUTO ACCIDENT	☐	☐		
	OTHER ACCIDENT?	☐	☐		
3) CITY, STATE ZIP	12) IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	☐	☐	(IF NO, REASON FOR REPLACEMENT)	DATE OF PRIOR PLACEMENT
4) DENTIST SS# OR TIN 5) DENTIST LISCENSE # 6) DENTIST PHONE #	13) IS TREATMENT FOR ORTHODONICS	☐	☐	IF SERVICES ALREADY COMMENCED, ENTER: / DATE APPLIANCES PLACED	MOS. TREATMENT REMAING

7) FIRST VISIT DATE CURRENT SERIES	8) PLACE OF TREATMENT	9) RADIOGRAPHS OR MODELS ENCLOSED?	HOW MANY?	14) DOES PATIENT HAVE OTHER DENTAL COVERAGE?	If YES, PLEASE IDENTIFY
	Office *Hosp* *ECF* *Other*	☐ YES ☐ NO		☐ YES ☐ NO	

Indicate missing teeth with an "X"



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

TOOTH # OR LETTER	SURFACE (ie., M,O, D, B, L, LA, I)	DESCRIPTION OF SERVICE INCLUDING X-RAYS, PROPI-IYLAXISMATERIALS USED, ETC.	DATE SERVICE PERFORMED MO. DA. YR	PROCEDURE NUMBER	FEE	FOR OFFICE USE ONLY

REMARKS FOR UNUSUAL SERVICES:

TOTAL FEE CHARGED		
PATIENT PAYS		
BALANCE		
PLAN %		
PLAN PAYS		

I HEREBY CERTIFY THE SERVICES LISTED ABOVE (☐ **WILL BE** ☐ **HAVE BEEN**) PERFORMED.	SIGNED (DENTIST)	DATE
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP PLAN BENEFITS NOT OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATON.	SIGNED (EMPLOYEE)	DATE
I HAVE REVIEWED THE FOREGOING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.	SIGNED (PATIENT, OR PARENT IF MINOR)	DATE

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