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BELL ATLANTIC

Dental Expense Claim Form

(Please Read Instructions on Reverse Side before Completing this Form)

1. Patient First Name | Middle | Last

2. Relationship to Employee: Self | Spouse | Child | Other

3. Sex: M | F

4. Married: Yes | No

5. Patient Date of Birth: Mo | Day | Year

6. Report Number: 39228/83844

7. If Full Time Student (Age 19 or Over) School | City | State

8. EMPLOYEE SOC. SEC. NO.

9. If Disabled (Age 19 or Over) ☐ Yes ☐ No

10. Name of Group Dental Program: Bell Atlantic

11. Employee First Name | Middle | Last

12. Employee Date of Birth

13. Office Phone (area code)

14. Employee Residence Mailing Address

15. City, State, Zip

16. Are other Family Members Employed? ☐ Yes ☐ No
Name | Soc. Sec. No.

17. Date of Birth

18. Name and Address of Employer for Item 16

19. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, Complete the Following) Dental Plan Name | Group No. | Name and Address of Carrier

20. I Authorize Release of any Information Relating to this Claim.
Signed (Patient, or Parent if Minor) | Date

21. I Certify that the Above Information is Correct.
Employee Signature | Date

22. I Authorize Payment Directly to the Below Named Dentist.
Employee Signature | Date

23. Dentist Name

24. Mailing Address

City, State, Zip

25. Dentist Soc. Sec. No. or T.I.N.

26. Dentist License No.

27. Dentist Phone No.

28. First Visit Date Current Series

29. Place of Treatment: Office | Hosp | ECF | Other

30. Radiographs or Models Enclosed? No | Yes | How Many?

31. Is Treatment Result of Occupational Illness or Injury? No | Yes — If Yes, Enter Brief Description and Dates

32. Is Treatment Result of Auto Accident? No | Yes

33. Other Accident? No | Yes

34. Are any Services Covered by Another Plan? No | Yes

35. If Prosthesis, is this Initial Placement? No | Yes — (If No, Reason For Replacement)

36. Date of Prior Placement

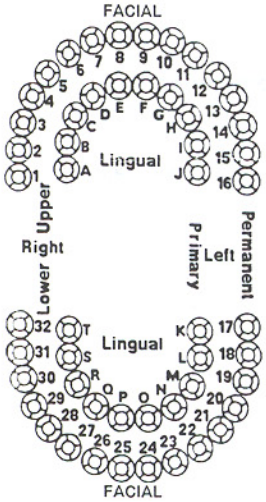
37. Is Treatment for Orthodontics? No | Yes — If Services Already Commenced, Enter | Date Appliance Placed | Mos. Treatment Remaining

Dentist's

☐ Pre-Treatment Estimate

☐ Statement of Actual Services

*(Be Sure To Sign Below)



INDICATE MISSING TEETH WITH AN "X"

38. 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 Services (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line No.	Date Service Performed Mo.	Day	Yr.	ADA Procedure Number	Fee	For Carrier Use Only
						Total Fee Actually Charged		

I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed

*Signed (Dentist) | Date

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