

Check One

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

UNITED CONCORDIA

Insuring America's Dental Health

Please submit claim to: **Dental Claims**
P.O. Box 69421
Harrisburg, PA 17106-9421

P A T I E N T S E C T I O N	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/subscriber name First middle last					9. Contract ID #					
	8. Employee/subscriber mailing address City, State, Zip					10. Employer (company) name and address					
	11. Group Number		12. Location (Local)		13. Are other family members employed? Employee name Contract ID #		14. Name and address of employer in item 13				
	15. Is patient covered by another dental plan?		Dental plan name		Union local		Group no.		Name and address of carrier		

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.

I hereby authorize payment directly to the below name dentist of the group insurance benefits otherwise payable to me.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature (patient or parent if minor) _____ Date _____ Signature (insured person) _____ Date _____

The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In health care operations as described in its Notice of Privacy Practices.

D E N T I S T S E C T I O N	16. Dentist name		24. Is treatment result of occupational illness or injury?		No	Yes	If yes, enter brief description and dates	
	17. Mailing address City, state, zip		25. Is treatment result of auto accident?					
	18. Dentist soc. sec. or T.I.N.		19. Dentist license no.		20. Dentist phone no.		28. If prosthesis, is this initial placement?	
	21. First visit date current series		22. Place of treatment Office Hosp. ECF Other		23. Radiographs or models enclosed?		No	Yes

26. Other accident?

27. Are any services covered by another plan?

29. Date of prior placement

30. Is treatment for orthodontics?

If services already commenced enter _____ Date appliances placed _____ Mos. treatment remaining _____

<p>Identify missing teeth with "X"</p>	31. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown.						Use charting system shown		FOR ADMINISTRATIVE USE ONLY	
	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO. DAY YR.			PROCEDURE CODE	FEE		

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.

TOTAL FEE CHARGED _____

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Signature (Dentist) _____ Date _____