

HEADER INFORMATION																																																																																											
1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services - OR - <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX																																																																																											
2. Predetermination/Preauthorization Number																																																																																											
PRIMARY PAYER INFORMATION																																																																																											
3. Name, Address, City, State, Zip Code																																																																																											
OTHER COVERAGE																																																																																											
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																																																																																											
5. Insured Name (Last, First, Middle Initial, Suffix)																																																																																											
6. Date of Birth (MM/DD/YYYY)			7. Gender <input type="checkbox"/> M <input type="checkbox"/> F			8. Insured Identifier (SSN or ID#)																																																																																					
9. Plan/Group Number			10. Relationship to Primary Insured (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																																																								
11. Other Carrier Name, Address, City, State, Zip Code																																																																																											
PRIMARY INSURED INFORMATION																																																																																											
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																											
13. Date of Birth (MM/DD/YYYY)				14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Insured Identifier (SSN or ID#)																																																																																					
16. Plan/Group Number				17. Employer Name																																																																																							
PATIENT INFORMATION																																																																																											
18. Relationship to Primary Insured (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other								19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS																																																																																			
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																											
21. Date of Birth (MM/DD/YYYY)			22. Gender <input type="checkbox"/> M <input type="checkbox"/> F			23. Patient ID/Account # (Assigned by Dentist)																																																																																					
RECORD OF SERVICES PROVIDED																																																																																											
	24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description			31. Fee																																																																																	
1																																																																																											
2																																																																																											
3																																																																																											
4																																																																																											
5																																																																																											
6																																																																																											
7																																																																																											
MISSING TEETH INFORMATION																																																																																											
34. (Place an 'X' on each missing tooth)																																																																																											
<table style="width:100%; border-collapse: collapse;"> <tr> <td colspan="16" style="text-align: center;">Permanent</td> <td colspan="10" style="text-align: center;">Primary</td> <td colspan="2" rowspan="2" style="vertical-align: middle;">32. Other Fee(s)</td> </tr> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td> <td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td><td>G</td><td>H</td><td>I</td><td>J</td> </tr> <tr> <td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td> <td>T</td><td>S</td><td>R</td><td>Q</td><td>P</td><td>O</td><td>N</td><td>M</td><td>L</td><td>K</td> <td colspan="2" style="vertical-align: middle;">33. Total Fee</td> </tr> </table>										Permanent																Primary										32. Other Fee(s)		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	
Permanent																Primary										32. Other Fee(s)																																																																	
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35. Remarks																																																																																											
AUTHORIZATIONS																																																																																											
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. I acknowledge that I have read the applicable fraud notice on page 2. X _____ Patient/Guardian signature Date																																																																																											
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X _____ Insured signature Date																																																																																											
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured.)																																																																																											
48. Name, Address, City, State, Zip Code																																																																																											
49. Provider ID			50. License Number			51. SSN or TIN																																																																																					
52. Phone Number ()																																																																																											
ANCILLARY CLAIM/TREATMENT INFORMATION																																																																																											
38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other						39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) [] [] []																																																																																					
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)				41. Date Appliance Placed (MM/DD/YYYY)																																																																																							
42. Months of Treatment Remaining			43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)			44. Date Prior Placement (MM/DD/YYYY)																																																																																					
45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																																																																																											
46. Date of Accident (MM/DD/YYYY)						47. Auto Accident State																																																																																					
TREATING DENTIST AND TREATMENT LOCATION INFORMATION																																																																																											
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. I acknowledge that I have read the applicable fraud notice on page 2. X _____ Signed (Treating Dentist) Date																																																																																											
54. Provider ID						55. License Number																																																																																					
56. Address, City, State, Zip Code																																																																																											
57. Phone Number ()						58. Treating Provider Speciality																																																																																					

Standard Insurance Company

Group Dental Insurance 800.547.9515 Tel 402.467.7336 Fax
PO Box 82622 Lincoln NE 68501

Claim Form Fraud Notices

Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

MARYLAND RESIDENTS

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

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 fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

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 fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.