Dental Claim Form

Complete and send to:
Meritain Health
P.O. Box 27267
Minneapolis, MN 55427-0267
Fax: 952.541.0193

IMPORTANT: Please have your dentist or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

1 EMPLOYEE INFORMATION

Name *(last, first, initial)*		Sex	Employer Name		
Home Address		Identification Number		Birthdate	Group Number
City	State	ZIP Code		Work Telephone ( )	Home Telephone ( )

2 PATIENT INFORMATION

The Patient is: ❑ THE EMPLOYEE *(go to No. 3)* ❑ EMPLOYEE'S SPOUSE *(complete spouse information)* ❑ EMPLOYEE'S CHILD *(complete spouse and child information)*

Spouse's Name (last, first, initial)		Sex	Child's Name (last, first, initial)		Sex
Spouse's Birthdate	Spouse's Social Security Number		Child's Birthdate	Child's Social Security Number	
Spouse's Employer			*If child is over age 19 and full-time student, complete:* Name of School:		
Spouse's Employer's Address			School Address		

3 OTHER COVERAGE

❑ YES *(then complete)* ❑ NO *(go to No. 4)* NAME OF POLICYHOLDER:

Name of Other Health Insurance Carrier or Plan	Address	City	State	ZIP Code
Other Insurance Carrier's or Plan's Telphone No.	Type of Coverage ❑ GROUP ❑ INDIVIDUAL	Group Number	Contract or Policy Number	
Spouse's Employer		*If child is over age 19 and full-time student, complete:* Name of School:		
Spouse's Employer's Address		School Address		

4 ABOUT THIS CLAIM

❑ INJURY ❑ ILLNESS
Date and time of accident:

Describe injury, when and how it happened or nature of illness:

Was injury the result of auto accident? ❑ YES ❑ NO
If auto insurance involved, please provide: Policy No | Name of Insurance Company | Address (City, State, ZIP Code)

Work related injury? ❑ YES ❑ NO

If injury is work related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.

5 EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

Signature _____ Date _____

6 ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)

I authorize payment of benefits directly to the dentist or supplier of services listed here.

Provider to be paid _____ Employee's Signature _____

Provider's Tax ID No. or Social Security No. _____ Date _____

MERITAIN HEALTH

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PHYSICIAN OR SUPPLIER STATEMENT

A

Patient Name (last, first, middle initial)	Birthdate
Address	

B

Dentist's Name			
Address			
City	State	ZIP Code	Telephone ( )

Provider's Tax ID No. or SSN: ☐ Dentist's License No.:

C

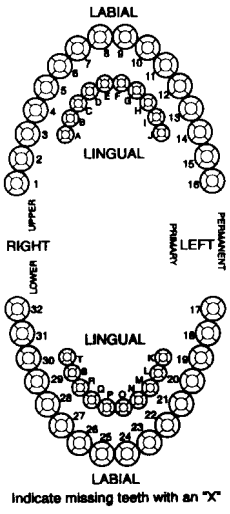
Is treatment a result of injury arising from patient's employment?	❑ YES ❑ NO	If yes, description and date:
Is treatment the result of an auto accident?	❑ YES ❑ NO	If yes, description and date:
Are any services covered by another plan?	❑ YES ❑ NO	If yes, name of other plan:
If prosthesis, is this an initial placement?	❑ YES ❑ NO	If no, reason for placement and date of previous placement:
Is treatment for orthodontics?	❑ YES ❑ NO	Date appliances placed: Mo. of treatment remaining:

D

Is this claim for a pre-treatment estimate?	❑ YES ❑ NO	If yes, are x-rays enclosed? ❑ YES ❑ NO

E

EXAMINATION AND TREATMENT RECORD



Tooth No. or Letter	Surface	Procedure Number (ADA)	Description of Services (include x-rays, prophylaxis, materials used, etc.)	Date of Service	Charges

F

I hereby certify that the above procedures have been completed on the date indicated.

Dentist's Signature _____ Date _____

STATUS AND BENEFIT INFORMATION:
1-800-925-2272

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