AULTCARE

Dental Claim Form

☐ Dentist's Pre-Treatment Estimate ☐ Dentist's Statement of Actual Services

PATIENT AND EMPLOYEE INFORMATION				
EMPLOYEE NAME First Name	Middle	Last		Phone Number
Contract/ Certificate Number	Business Phone Number			Social Security Number
Street	City		State	Zip Code
Employer Name Employer Location			Group Number (if shown on your ID card)	
PATIENT NAME First Name	Middle	Last		
Date of Birth	Age	Relation to Employee		
Do you or your spouse have other dental insurance? ☐ Yes ☐ No If yes, is the patient covered under your dental insurance? ☐ Yes ☐ No				
Policyholder's Name	Other Insurance Company Name			
Policyholder's Employer	Contract/Social Security Number			

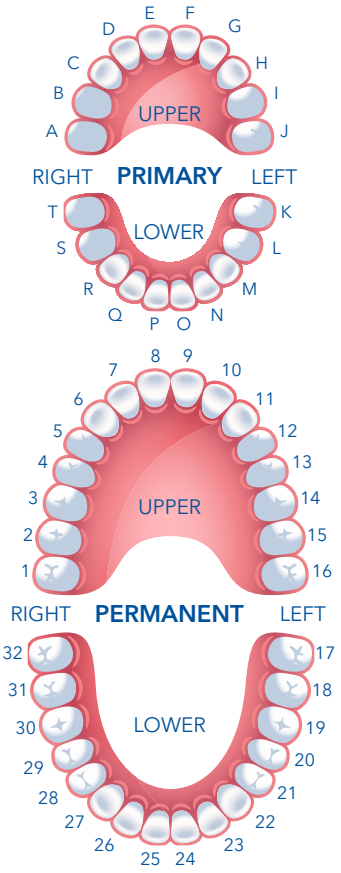
Certification of Information: Any person who knowingly and with intent to deceive files a statement of claim containing any materially false or misleading information is guilty of a crime. Please review this form thoroughly. Make certain all information is accurate and complete. Errors or omissions can result in payment delays or forfeiture of benefits. I certify the information on this form is accurate and complete to the best of my knowledge.

Release of Information: I hereby authorize the provider of services to release any information acquired in the course of my examination or treatment to my Plan Administrators.

Signature (patient, or parent, if minor) _____ Date _____

Authorization to Pay Benefits to Dentist: I hereby authorize payment directly to the undersigned provider of services, if any, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services.

Employee Signature _____ Date _____



EXAMINATION AND TREATMENT RECORD

List in order from tooth number 1 through tooth number 32.

Tooth # or Letter	Surfaces	Description of Service (x-rays, prophylaxis, materials used, etc.)	Date of Service Performed (MMDDYYYY)	Fee for Each Service Performed	Procedure Code Number	Reserved for Processing Use
			Total			

Please indicate if service was provided:

☐ For orthodontic purposes ☐ In patient's home or hospital ☐ As a result of occupational injury

☐ As a result of accident Date of accident _____

If a prosthesis, is this an initial placement? ☐ Yes ☐ No | Date of prior replacement

If no, please indicate reason for replacement

Are x-rays enclosed? ☐ Yes ☐ No | If yes, number of x-rays

DENTIST INFORMATION

First Name	Middle	Last	
Street	City	State	Zip Code
Office Phone Number	T.I.N or Social Security Number	Practice Specialty	

Additional comments
(unusual services or circumstances)

I certify the services shown above are planned or have been performed.

Dentist Signature _____ Date _____

Stamp

Please return this form to: AultCare PO Box 6910 Canton, OH 44706
If you have questions, please contact AultCare at 330-363-6360 or 1-800-344-8858 (TTY: 711), via fax at 330-470-4757, or via email at ancillaryclaimsservices@aultcare.com.