DENTAL CLAIM FORM

PATIENT INFORMATION

1. PATIENT'S NAME (first name, middle initial, last name)	2.PATIENT'S DATE OF BIRTH	3. PATIENT'S SOCIAL SECURITY #
4. PATIENT'S ADDRESS (if different from employee)	5. PATIENT'S SEX ❑MALE ❑FEMALE	6. TELEPHONE NUMBER
7. EMPLOYEE'S NAME (first name, middle initial, last name)	8. EMPLOYEE'S IDENTIFICATION #	9.EMPLOYEE'S ADDRESS (city, state, and zip code)

10. PATIENT'S RELATIONSHIP TO EMPLOYEE	11. FULL-TIME STUDENT? ❑YES ❑NO	12. ANY OTHER DENTAL COVERAGE? IF SO, WITH WHOM?
13. I AUTHORIZE PAYMENT TO PROVIDER ❑YES ❑NO	14. EMPLOYER NAME **WASHTENAW COUNTY ROAD COMMISSION**	

17. To all dentists, dental health professionals, all hospitals and other health care institutions: You are authorized to provide Professional Benefits Services, Inc. and any independent claim administrators and consulting health professionals and utilization review organizations with whom PBS has contracted, information concerning health care, advice, treatment or supplies provided the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.

PBS may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operating of the policy or contract.

This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

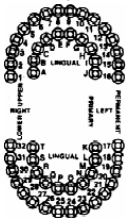
SIGNED (Employee or Authorized Person) X _____ DATE _____

DENTIST'S INFORMATION

1. DENTIST NAME	9. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
2. MAILING ADDRESS IS THIS A NEW ADDRESS? ❑YES ❑NO	10. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	11. OTHER ACCIDENT?			
CITY, STATE, and ZIP CODE	12. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			

3. ENTER THE TAYPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER.	4. DENTIST LICENSE NO. / 5. DENTIST TELEPHONE NO.	13. IF PROTHESIS, IS THIS INITIAL PLACEMENT?		IF NO, REASON FOR REPLACEMENT	14. DATE OF PRIOR REPLACEMENT?
6. FIRST VISIT DATE CURRENT SERIES	7. PLACE OF TREATMENT ❑OFFICE ❑ HOSPITAL ❑ECF ❑ OTHER	8. RADIOGRAPHS OR MODELS ENCLOSED? ❑YES ❑NO HOW MANY?	15. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACES_____ MONTHS TREATMENT REMAINING_____

IDENTIFY MISSING TEETH WITH AN "X"
FACIAL



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16. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH # 1 THROUGH TOOTH #32. USE CHARTING SYTEM SHOWN.

TOOTH # OR LETTER	17. IF PREVIOUSLY EXTRACTED GIVE DATE EXTRACTED BELOW	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC…) LINE NO	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER		FEE
	1								
	2								
	3								
	4								
	5								
	6								
	7								
	8								
	9								
	10								
	11								
	12								

18. 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 THIS PATIENT AND INTEND TO ACCEPT PAYMENT FOR THOSE PROCEDURES.

X_____ SIGNED (DENTIST) _____ DATE

TOTAL FEE CHARGED		
AMOUNT PAID		

MAIL TO: **Varipro**
PO Box 211657 Eagan, MN 55121
EDI PAYER ID: 72187

Telephone:
1-616-285-2480 or 1-800-732-3412

Varipro BENEFIT ADMINISTRATORS