DENTAL CLAIM FORM

MAIL TO: CNIC
P.O. Box 3559
Englewood, CO 80155-3559

JULIAN DATE

REC. NO.

Part 1 — TO BE COMPLETED BY EMPLOYEE

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 NAME — FIRST | MIDDLE | LAST
7. EMPLOYEE SOCIAL SECURITY NO
9. NAME OF GROUP DENTAL PROGRAM: **Delta County School District 50J**
8. EMPLOYEE MAILING ADDRESS
CITY, STATE | ZIP
10. EMPLOYER (COMPANY) NAME AND ADDRESS
11. GROUP: **329**
12. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME | SOC SEC NO — NO ☐ YES ☐
13. NAME AND ADDRESS OF EMPLOYER IN ITEM 13
14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO ☐ YES ☐ | DENTAL PLAN NAME | UNION LOCAL | GROUP NO | NAME AND ADDRESS OF CARRIER

Part 2 — TO BE COMPLETED BY ATTENDING DENTIST

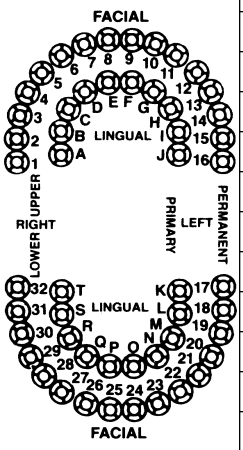
I hereby certify to the above statements ✔ — Employee's Signature | Date

I authorize my attending dentist to release any information relating to the claim ✔ — Patient's Signature (Parent if a minor) | Date

15. DENTIST NAME
16. MAILING ADDRESS
CITY, STATE. | ZIP
17. DENTIST SOC SEC OR TIN
18. DENTIST LICENSE NO.
19. DENTIST PHONE NO.
20. FIRST VISIT DATE
21. PLACE OF TREATMENT — OFFICE | HOSP | ECF | OTHER
22. RADIOGRAPHS OR MODELS ENCLOSED — NO | YES | HOW MANY
23. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? — NO | YES | IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF AUTO ACCIDENT? — NO | YES
25. OTHER ACCIDENT? — NO | YES
26. ARE ANY SERVICES COVERED BY ANOTHER PLAN? — NO | YES
27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? — NO | YES | (IF NO, REASON FOR REPLACEMENT) | 28. DATE OF PRIOR PLACEMENT
29. IS TREATMENT FOR ORTHODONTICS? — NO | YES | IF SERVICES ALREADY COMMENCED, ENTER | DATE APPLIANCES PLACED | MOS TREATMENT REMAINING

DENTIST — CHECK ONE
☐ PRETREATMENT ESTIMATE
☐ STATEMENT OF ACTUAL SERVICES

IDENTIFY MISSING TEETH WITH "X"



30. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED. ETC.)	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE		ADMINISTRATIVE USE ONLY BASIC		MAJOR	

31. REMARKS FOR UNUSUAL SERVICES

TOTAL FEE CHARGED

Part 4 — TO BE COMPLETED BY EMPLOYEE — IMPORTANT — READ CAREFULLY

CERTIFICATION I hereby certify that I have reviewed the plan of treatment and the fees to be charged

EMPLOYEE'S SIGNATURE: DATE

ASSIGNMENT I hereby assign benefits payable to the attending dentist

EMPLOYEE'S SIGNATURE: DATE

Part 5 — TO BE COMPLETED BY DENTIST

I hereby certify that the services listed above have been performed on the above named patient on the dates indicated

DENTIST'S SIGNATURE: DATE

If applicable					
	Deductible				
	% Payable				
	Amt Payable				

These benefits will be subject to policy provisions, be payable if the described procedures are performed during a period of the patient's eligibility. (The patient's personal eligibility has not been verified at the time of predermination.)

	PLAN PAYS ➧	
	PATIENT PAYS ➧	

(over)

DENTAL CLAIM INSTRUCTIONS

Before submitting your claim, make sure that all required information on the claim form has been completed and that you have signed the appropriate signature blocks. Failure to complete applicable information may **DELAY** payment of your claim.

TIMELY CLAIMS SUBMISSION: All claims are required to be submitted prior to July 1 of the next calendar year. If claims are not submitted within these guidelines, payment will not be assured.

1. **PART 1** — Must be completed in its entirety by the **EMPLOYEE.** Be sure that #15 relating to the other group coverage is completed if applicable.

2. **PART 2** — Is to be completed by the **DENTIST,** or a comparable dental form may be attached to the Delta County School District 50J form.

3. When the claim is being submitted for payment, be sure that **PART 4** and **PART 5** are signed by the applicable people. If in **PART 4** you assign benefits, Delta County School District 50J will make payment to the dentist; if you do not wish to assign benefits, Delta County School District 50J will make payments to you.

4. If the claim is for **ORTHODONTICS**, the dentist needs to list the total fee, the class of malocclusion (diagnosis), how long the treatment will last, and the date that the appliances (braces) were placed.

MAIL CLAIMS TO:

CNIC
P.O. Box 3559
Englewood, CO 80155-3559

NOTE: PROVIDERS OR MEMBERS—FOR INFORMATION,
PLEASE CALL THE URMAN COMPANY (303) 773-1373 OR 1-800-332-1168