

Dental Claim Form



School Insurance Specialists

MAIL CLAIMS TO:
SET SEG
Dental Claims Unit
 415 W. Kalamazoo
 Lansing, MI 48933
 1-800-292-5421

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's stmt. of actual services Prov. ID #	2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT Prior Auth. # Patient ID #
--	--

4. Patient name first _____ m.i. _____ last _____	5. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____	6. Sex m _____ f _____	7. Patient birthdate MM DD YYYY	8. If full time student school _____ city _____
--	---	---------------------------	------------------------------------	--

9. Employee/subscriber name and mailing address	10. Employee/subscriber contract number	11. Employee/subscriber birthdate MM DD YYYY	12. Employer (company) name and address	13. Group number
---	---	---	---	------------------

14. Is patient covered by another dental plan? ____ yes ____ no If yes, complete 15-a. Is patient covered by a medical plan? ____ yes ____ no	15-a. Name and address of carrier(s)	15-b. Group no.(s)	16. Name and address of other employee(s)
---	--------------------------------------	--------------------	---

17-a. Employee/subscriber name (if different than patient's)	17-b. Employee/subscriber dental plan I.D. number	17-c. Employee/subscriber birthdate MM DD YYYY	18. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____
--	---	---	---

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless 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 under applicable law, I authorize release of any information relating to this claim.	20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
> _____ Date _____ Signed (Patient, or parent if minor)	> _____ Date _____ Signed (Employee/subscriber)

21. Name of Billing Dentist or Dental Entity	30. Is treatment result of occupational illness or injury? No _____ Yes _____ If yes, enter brief description and dates.
--	--

22. Address where payment should be remitted	31. Is treatment result of auto accident? No _____ Yes _____
--	---

23. City, State, ZIP	32. Other accident? No _____ Yes _____
----------------------	---

24. Dentist Soc. Sec. or T.I.N.	25. Dentist license no.	26. Dentist phone no.	33. If prosthesis, is this initial placement? No _____ Yes _____	(If no, reason for replacement)	34. Date of prior placement
---------------------------------	-------------------------	-----------------------	---	---------------------------------	-----------------------------

27. First visit date current series	28. Place of treatment Office _____ Hosp. _____ ECF _____ Other _____	29. Radiographs or models enclosed? No _____ Yes _____	How many? _____	35. Is treatment for orthodontics? No _____ Yes _____	If services already commenced enter: _____ Date appliances placed _____ Mos. treatment remaining _____
-------------------------------------	--	---	-----------------	--	--

36. Identify missing teeth with "x"	37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.					For administrative use only
	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

38. Remarks for unusual services.	
-----------------------------------	--

39. 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 and intend to collect for those procedures.	41. Total Fee Charged	
> _____ Signed (Treating Dentist)	42. Payment by other plan	
_____ License Number _____ Date _____	Max. Allowable	

40. Address where treatment was performed	Deductible	
	Carrier %	
	Carrier pays	
	Patient pays	