Trustmark
INSURANCE COMPANY

Voluntary Dental Claims
P.O. Box 2979 • Clinton, IA 52733-2979
(800) 371-1633

DENTAL INSURANCE CLAIM FORM

Pre-authorization required for all treatment plans in excess of $300

☐ DENTIST'S PRE-TREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

Any person who knowingly and with intent to defraud, files a statement of claim containing false or misleading information may be committing insurance fraud which may be a crime.

EMPLOYEE'S INFORMATION

PATIENT NAME	RELATIONSHIP TO EMPLOYEE: SELF / SPOUSE / CHILD / OTHER	SEX: M / F	PATIENT BIRTH DATE: MO / DAY / YEAR	IF FULL-TIME STUDENT: SCHOOL / CITY

EMPLOYEE NAME: First / Middle / Last	DATE OF BIRTH	EMPLOYEE'S SOCIAL SECURITY NUMBER

EMPLOYEE ADDRESS	EMPLOYER NAME AND ADDRESS

CITY, STATE, ZIP

GROUP NUMBER	ARE OTHER FAMILY MEMBERS EMPLOYED? ☐YES ☐NO EMPLOYEE NAME / SOC. SEC. NO.	NAME AND ADDRESS OF OTHER EMPLOYER
VP		

IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐YES ☐NO	DENTAL PLAN NAME	EMPLOYEE I.D. NO.	GROUP NO.	NAME AND ADDRESS OF CARRIER

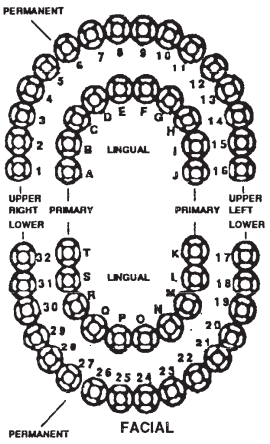
I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.	I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
SIGNED (PATIENT OR PARENT IF MINOR) / DATE	SIGNED (PATIENT OR PARENT IF MINOR) / DATE

DENTIST'S INFORMATION

DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? YES / NO	IF YES, ENTER BRIEF DESCRIPTION AND DATES
CORPORATION NAME	IS TREATMENT RESULT OF AUTO ACCIDENT?	
MAILING ADDRESS	IS TREATMENT RESULT OF OTHER TYPE OF ACCIDENT?	
CITY, STATE, ZIP	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	(IF NO, REASON FOR REPLACEMENT) / DATE OF PRIOR PLACEMENT
T.I.N. / LICENSE NO.	IS TREATMENT FOR ORTHODONTICS?	IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

TELEPHONE NO.	FAX NO.	FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT: OFFICE HOSP ECF OTHER	RADIOGRAPHS OR MODELS ENCLOSED? ☐YES ☐NO	HOW MANY?
( )	( )				

IDENTIFY MISSING TEETH WITH "X"



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 MATERIAL USED, ETC.)	DATE SERVICE PERFORMED MO	DAY	YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY I II III IV CHARGES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST) / DATE

Form approved by the Council on Dental Care Program of the A.D.A. 1975

VP7 (8-02)

INTERNET