ATTENDING DENTIST'S STATEMENT

DENTAL PLUS CLAIM FORM

UNITED SECURITY
LIFE AND HEALTH INSURANCE COMPANY
P.O. Box 24655, Seattle, WA 98124

PATIENT INFORMATION

1. PATIENT NAME
2. RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
3. SEX — M ☐ F ☐
4. PATIENT BIRTH DATE — MO. / DAY / YEAR
5. IF FULL-TIME STUDENT — SCHOOL / CITY
6. INSURED NAME — FIRST / MIDDLE / LAST
7. INSURED SOCIAL SECURITY NO.
8. INSURED MAILING ADDRESS
9. DENTAL PLUS POLICY #
10. EMPLOYER (COMPANY) NAME AND ADDRESS
11. INSURED OTHER DENTAL COVERAGE
12. POLICY #
13. ARE OTHER FAMILY MEMBERS EMPLOYED? — NAME / SOC. SEC. #
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? — DENTAL PLAN NAME / GROUP NUMBER / NAME AND ADDRESS OF EMPLOYER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT

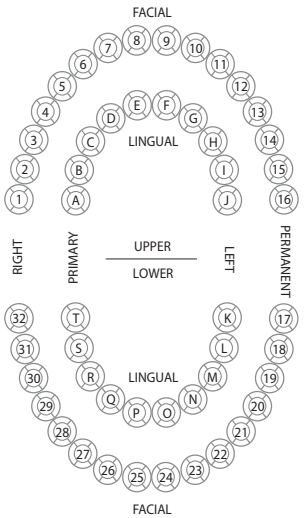
SIGNED (PATIENT OR PARENT IF MINOR) DATE

DENTIST INFORMATION

16. DENTIST NAME
17. MAILING ADDRESS — CITY, / STATE, / ZIP
18. DENTIST SOC. SEC OR T.IN.
19. LICENSE NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT — OFFICE ☐ HOSP. ☐ ECF ☐ OTHER ☐
23. RADIOGRAPHS OR MODELS ENCLOSED — NO ☐ YES ☐ — HOW MANY

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES

31. 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, PROHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

SUBMIT RECEIPTS FOR PAYMENTS MADE TO DENTAL PROVIDER

TOTAL FEE CHARGED	
MAX ALLOWED	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	