Dental Claim Form

Check one:
- ☐ Dentist's pre-treatment estimate
- ☐ Dentist's statement of actual services

Carrier name and address: **Hewitt, Coleman & Associates, Inc.**
Post Office Box 6708
Greenville, South Carolina 29606

Patient Coverage Information

1. Patient name First M.I. Last	2. Relationship to employee ☐ Self ☐ Parent ☐ Spouse ☐ Other_______	3. Sex M | F	4. Patient Birthdate MM | DD | YYYY	5. If full-time student: School: City:

6. Employee/subscriber name and mailing address:	7. Employee/Subscriber Soc. Sec. Or I.D. Number	8. Employee/Subscriber Birthdate MM | DD | YYYY	9. Employer (company) name and address:	10. Group Number

11. Is patient covered by another dental plan? ☐ Yes ☐ No Is patient covered by another medical plan? ☐ Yes ☐ No If yes, complete 12-a	12-a. Name and address of carrier(s)	12-b. Group Number(s)	13. Name and address of other employer(s)

14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/Subscriber Soc. Sec. Or I.D. Number	14-c. Employee/Subscriber Birthdate MM | DD | YYYY	15. Relationship to patient ☐ Self ☐ Parent ☐ Spouse ☐ Other_____________

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

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

____ ____________________

Signed (Insured Person) Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity		24. Is treatment result of occuplational illness or injury?	No	Yes	If yes, enter brief description and dates.	
17. Address where payment should be remitted		25. Is treatment result of auto accident?				
City, State, Zip	18. Dentist's Phone Number	26. Other accident?				
19. Dentist Soc. Sec. Or T.I.N.	20. Dentist's License No.	27. If prosthesis, is this initial placement?			If no, reason for replacement	28. Date of Prior Placement

21. First visit date current series	22. Placement of treatment Office | Hosp | ECF | Other	23. Radiographs or models enclosed? Yes | No | How Many	29. Is treatment for orthodontics?			If services already commenced enter?	Date appliances placed?	Mos. treatment remaining?

Identify missing teeth with "X"

FACIAL
LINGUAL
UPPER
RIGHT
LOWER
PRIMARY
LEFT
PERMANENT
LINGUAL
FACIAL

30. Examination and treatment plan - List in order from Tooth No. 1 through Tooth No. 32 - Using chart 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	For Administrative Use Only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charges and intend to collect for those procedures.

____ ____________________

Signed (Treating Dentist) License Date

Total Fee Charged