Check One

☐ Dentist's pre-treatment estimate

☐ Dentist's statement of actual services

UNITED CONCORDIA

America's Premier Dental Insurer

Please submit claim to: Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

PATIENT SECTION

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/subscriber name: First / middle / last

9. Contract ID #

8. Employee/subscriber mailing address

City, State, Zip

10. Employer (company) name and address

11. Group Number | 12. Location (Local) | 13. Are other family members employed? Employee name / Contract ID # | 14. Name and address of employer in item 13

15. Is patient covered by another dental plan? | Dental plan name | Union local | 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 understand that I am responsible for all costs of dental treatment.

I hereby authorize payment directly to the below name dentist of the group insurance benefits otherwise payable to me.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature (patient or parent if minor) | Date | Signature (insured person) | Date

The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, United Concordia may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices.

DENTIST SECTION

16. Dentist name

17. Mailing address

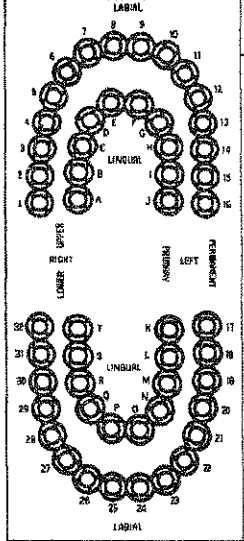
City, state, zip

18. Dentist soc. sec. or T.I.N. | 19. Dentist 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	
24. Is treatment result of occupational illness or injury?			If yes, enter brief description and dates
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"



31. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown. Use charting system shown

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED,ETC.) LINE NO.	DATE SERVICE PERFORMED MO.	DAY	YR.	PROCEDURE CODE	FEE	FOR ADMINISTRATIVE USE ONLY

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.

TOTAL FEE CHARGED

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Signature (Dentist) _____ Date _____