DENTAL CLAIM FORM

INSTRUCTIONS

- Employee should complete Part 1.
- Dentist should complete Part 2 & 3.
- Completed form should be mailed to:

TPSC Benefits Claims Administrator:
P.O. Box 2950; Tacoma, WA 98401

Phone: 253.564.5611 ext. 210
Fax: 253.564.5881
Toll Free: 800.426.9786 ext. 210

PART 1: TO BE COMPLETED BY EMPLOYEE

Patient Name:			Birth Date:
Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Sex: ☐ Male ☐ Female	Full-Time Student? ☐ Yes ☐ No		
Employee Full Name:			Social Security #:
Mailing Address:			
City:	State:	Zip:	☐ Check if New Address
Employer Name:			
Employer Address:			
State:	Zip:	Phone #:	Group/Plan #:
Are other family members employed? ☐ Yes ☐ No			
Dependent Name:			Social Security #:
Name of Employer:			
Employer Address:		State:	Zip:
Is Patient Covered By Another Dental Plan? ☐ Yes ☐ No			
Union Local:		Group #:	
Name and Address of Insurance Co. or Plan:		State:	Zip:

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN.
I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Signature _____ Date _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO MY DENTIST OF THE BENEFITS OTHERWISE PAYABLE TO ME.

Signature _____ Date _____

TPSC BENEFITS

DENTAL CLAIM FORM

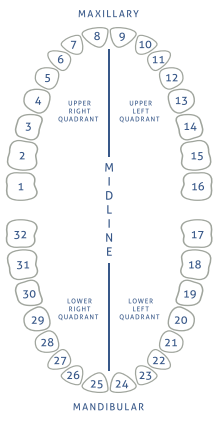
PART 2: TO BE COMPLETED BY DENTIST

Dentist Name:		Phone #:	
Mailing Address:	City:	State:	Zip:
Dentist T.I.N. #:	License #:		
First visit date current series:			
Place of Treatment: ☐ Office ☐ Hospital ☐ ECF ☐ Other		Radiographs or models enclosed? ☐ Yes ☐ No	
Is treatment result of occupational illness or injury?		☐ Yes ☐ No	
If "yes", enter brief description and dates:			
Is treatment result of auto accident? Other accident?		☐ Yes ☐ No	
Are any services covered by another plan?		☐ Yes ☐ No	
If prosthesis, is this initial placement?		☐ Yes ☐ No	
If "no", reason for replacement and date of prior replacement:			
Is treatment for orthodontics?		☐ Yes ☐ No	
If services already commenced, enter:			
Date Appliances Placed:	Mos. Treatment Remaining:		

PART 3: TO BE COMPLETED BY DENTIST

EXAMINATION AND TREATMENT PLAN

List in order from tooth no. 1 – use charting system shown.



Tooth # or Letter	Surface	Description of Service *(Including x-rays, prophylaxis, material used, etc.)*	Date Service Performed MO / Day / YR	Procedure Number	Fee	Amount of Benefits

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

Signed *(Dentist)* _____ Date _____

Total Fee Charged	
Max Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	