

**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**E-mail:** benefitssupport@tpscbenefits.com**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



PART 2: TO BE COMPLETED BY DENTIST

PART 3: TO BE COMPLETED BY DENTIST

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

[illegible]