MAXOR® Administrative Services

Dental Expense Claim

To Be Completed by Employee

1. Patient First Name — Middle — Last	2. Relationship to Employee O Self O Spouse O Child O Other	3. Sex O Male O Female	4. Married? O Yes O No

5. EMPLOYEE Social Security / ID Number	6. Patient Date of Birth Mo. / Day / Year	7. Name of Group

8. Employee First Name — Middle — Last	9. Employee Date of Birth	10. Office Phone (Area Code)

11. Employee Residence Mailing Address	12. City, State, Zip

13. Are other Family Members Employed? O Yes O No Name — Social Security / ID Number	14. Date of Birth	15. Name and Address of Employer for Item 16

16. Is Patient Covered by Another Dental Plan? O Yes O No (If Yes, complete the following:)
Dental Plan Name — Group No. — Name and Address of Carrier

17. I Authorize Release of any Information Relating to this Claim (Signature of Patient or Signature of Authorized Representative if Minor) — Date If Authorized Representative, Relationship to Minor	18. I Certify that the Above Information is Correct. Employee Signature — Date	19. I Authorize Payment Directly to the Bebw Named Dentist. Employee Signature — Date

To Be Completed by Dentist

20. Dentist Name	21. Mailing Address — City — State — Zip

22. Dentist Social Security Number or T.I.N.	23. Dentist License Number	24. Dentist Phone Number

25. First Visit Date Current Series	26. Place of Treatment O Office O Hospital O ECF O Other ______	27. Radiographs or Models Enclosed? O Yes O No How Many?______

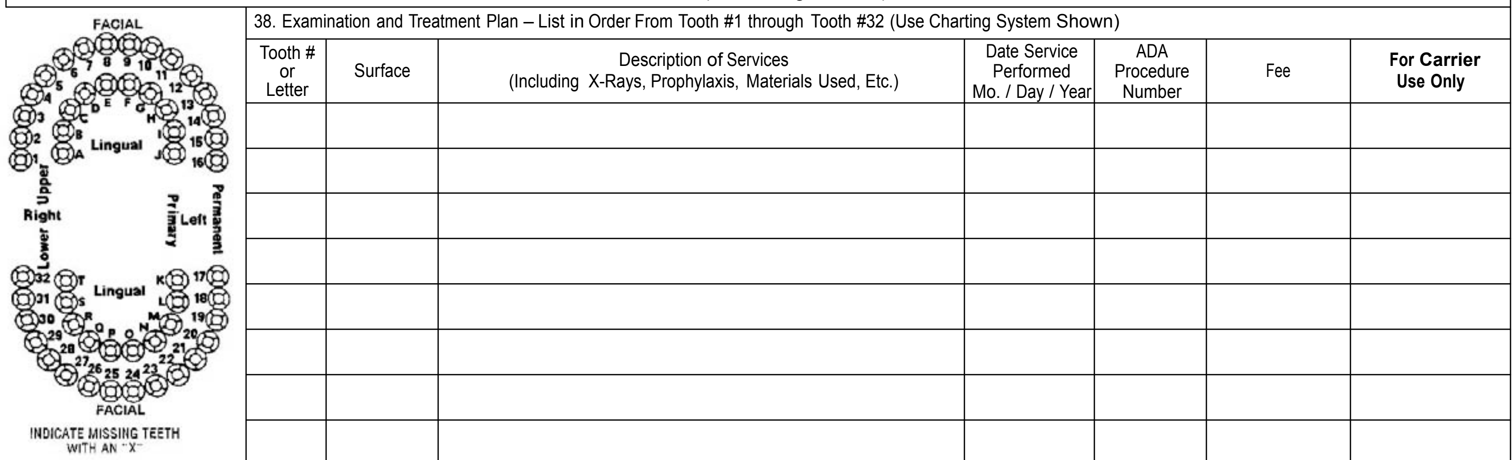
28. Is Treatment Result of Occupational Illness or Injury? O Yes O No (If Yes, Enter Brief Description and Dates)	29. Is Treatment Result of Auto Accident? O Yes O No (If Yes, Enter Brief Description and Dates)

30. Other Accident? O Yes O No (If Yes, Enter Brief Description and Dates)	31. Are any Services Covered by Another Plan? O Yes O No (If Yes, Enter Brief Description and Dates)

32. If Prosthesis, is this Initial Placement? O Yes O No (If No, Reason for Replacement)	33. Date of Prior Replacement?

34. Is Treatment for Orthodontics? O Yes O No	If Services Already Commenced, Enter Date Appliance Placed	Months of Treatment Remaining

Dentist's — O Pretreatment Estimate O Statement of Actual Services (Please sign below)*



38. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)

Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo. / Day / Year	ADA Procedure Number	Fee	**For Carrier Use Only**

35. I Hereby Certify That The Services Listed Above O Will Be O Have Been Performed

* Signature of Dentist ______________________ Date ____________ Total Fee Actually Charged

36. Address where treatment was performed

Street ______________________ City ______________ State ________ Zip ________