SPECTRUM ADMINISTRATORS
"Managing The Cost Of Caring℠"

DENTAL PLAN CLAIM FORM

TO BE COMPLETED BY EMPLOYEE

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 / STATE
6. EMPLOYEE NAME — FIRST / MIDDLE / LAST
   EMPLOYEE'S BIRTHDAY — MO / DAY / YEAR
7. EMPLOYEE ID #
8. MARITAL STATUS — □ SINGLE □ DIVORCED □ MARRIED
   SPOUSE'S BIRTHDAY — MO / DAY / YEAR
9. EMPLOYEE MAILING ADDRESS
   CITY, STATE / ZIP
10. EMPLOYER
11. ARE OTHER FAMILY MEMBERS EMPLOYED? □ NO □ YES
12. EMPLOYEE NAME / MEMBER ID #
13. NAME AND ADDRESS OF EMPLOYER IN ITEM 12
14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? □ NO □ YES
    DENTAL PLAN NAME / NAME AND ADDRESS OF CARRIER
15. IF PATIENT IS A DEPENDENT CHILD ARE THESE PARENTS DIVORCED OR SEPARATED? □ NO □ YES
    IF YES, (A) WHO HAS PRIMARY CUSTODY?
    □ NATURAL MOTHER □ NATURAL FATHER □ OTHER _____
    (B) IS THERE A LEGAL DOCUMENT DIRECTING EITHER PARENT TO PROVIDE INSURANCE COVERAGE FOR THIS DEPENDENT?
    □ NO □ YES WHICH PARENT? _____
    PLEASE ATTACH A COPY OF THIS DOCUMENT IF NOT PREVIOUSLY PROVIDED.
16. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM
    _____ SIGNED (PATIENT OR PARENT IF MINOR) _____ DATE
17. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT
    _____ EMPLOYEE'S SIGNATURE _____ DATE

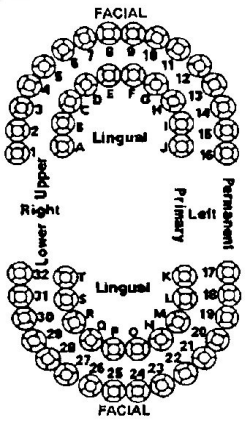
TO BE COMPLETED BY DENTIST

18. DENTIST NAME — FIRST / MIDDLE / LAST
19. MAILING ADDRESS
    CITY, STATE / ZIP
20. DENTIST SOC SEC OR TIN
21. DENTIST LICENSE NO.
22. DENTIST PHONE NO.
23. FIRST VISIT CURRENT SERIES
    PLACE OF TREATMENT — OFFICE / HOSP / ECF / OTHER
24. RADIOGRAPHS OR MODELS ENCLOSED? — NO / YES / HOW MANY?

	NO	YES	IF YES ENTER DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
26. IS TREATMENT RESULT OF AUTO ACCIDENT? 27. OTHER ACCIDENT?			
28. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
29. IF PROSTHESIS CROWN OR INLAY IS THIS INITIAL PLACEMENT?			IF NO REASON PRIOR FOR REPLACEMENTS / 30. DATE OF PLACEMENTS
31. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCE PLACED / MOS. TREATMENT REMAINING

DENTIST (CHECK ONE)
□ PRETREATMENT ESTIMATE
□ STATEMENT OF ACTUAL SERVICES

IDENTIFY MISSING TEETH WITH AN "X"



REMARKS FOR UNUSUAL SERVICES

TOOTH NO. OR LTR.	SURFACE	DESRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLASIS MATERIALS USED ETC.)	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE
		TOTAL FEE CHARGED					

TO BE COMPLETED BY DENTIST

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 THIS PATIENT AND INTEND TO ACCEPT FOR THESE PROCEDURES.

DENTIST'S SIGNATURE:_____ DATE:_____

DIRECTION TO PAY BENEFITS TO DENTIST

I HEREBY DIRECT BENEFITS PAYABLE TO THE ATTENDING DENTIST.

EMPLOYEE'S SIGNATURE:_____ DATE:_____

FORWARD CLAIMS TO: SPECTRUM ADMINISTRATORS, INC., 2166 SOUTH 12TH STREET, ALLENTOWN, PA 18103
INQUIRIES TO: 610-969-0410 OR 1-800-925-8459