SouthlandBenefit Administrators

A Division of Southland National Insurance Corporation

DENTAL CLAIM FORM

CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 365 DAYS FROM DATE OF SERVICE.

CHECK ONE: ☐ DENTIST'S PRE-TREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

1. Patient's Name	2. Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	3. Sex ☐ M ☐ F	4. Patient's Birthdate Mo Day Year	5. If Full Time Student School City

6. Subscribers Name First Middle Last	7. Subscriber's Contract Number	8. Name of Group Dental Program

9. Subscriber's Mailing Address	10. Subscriber's Group Name and Address
City, State, Zip	City, State, Zip

11. Group Number	12.	13. Are other family members employed? Subscriber's Name Social Security No.	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.	Signed (Patient or Parent, if Minor)	Date
AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me.	Signed (Insured Person)	Date

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO FILES A STATEMENT 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.

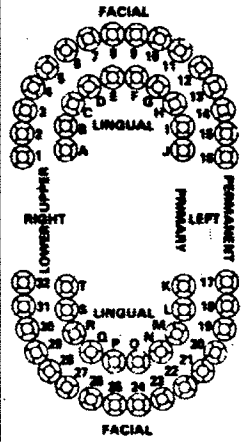
16. Dentist's Name	20. Is Treatment for Orthodontics? ☐ Yes ☐ No	If Services Already Commenced Enter	Date Appliances Placed	Mos. Treatment Remaining

17. Mailing Address	21. Are Any Services Covered by Another Plan? ☐ Yes ☐ No If Yes, Name of Other Plan:

City, State, Zip	22. If Prosthesis, is This Initial Placement? If No, Reason for Replacement ☐ Yes ☐ No	Date of Prior Placement

18. Dentist's Social Security or T.I.N.	19. Dentist's Telephone No.	23. First Visit Date Current Series	24. Place of Treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other	25. Radiographs or Models Enclosed? ☐ Yes ☐ No How many?_____

Identify Missing Teeth with "X"



26. Examination & 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.)* Line No.	Date of Service Performed Mo. Day Year	Procedure Number	Fee	For Administrative Use Only
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.	SIGNED (DENTIST)	DATE	TOTAL FEE CHARGED	