



# DENTAL CLAIM NOTICE

**Health Net Dental**  
 P.O. Box 30930  
 Laguna Hills, CA 92654-0930  
 (800) 880-8113

CHECK ONE:  
 PRE DETERMINATION ESTIMATE  
 STATEMENT OF ACTUAL SERVICES

## PART 1- EMPLOYEE: READ INSTRUCTIONS CAREFULLY BEFORE YOU COMPLETE

1. PATIENT NAME		2. PATIENT RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F		4. PATIENT BIRTHDATE MO DAY YEAR		5. IF FULL TIME STUDENT NAME OF SCHOOL		CITY	
6. EMPLOYEE NAME FIRST MIDDLE LAST						7. EMPLOYEE SOCIAL SECURITY NUMBER		8. EMPLOYEE CERT. #			
9. EMPLOYEE MAILING ADDRESS						10. EMPLOYER (COMPANY) NAME AND ADDRESS					
CITY, STATE, ZIP						CITY, STATE, ZIP			GROUP NUMBER		
11. EMPLOYEE HOME PHONE			12. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME <input type="checkbox"/> YES <input type="checkbox"/> NO				13. NAME AND ADDRESS OF EMPLOYER SOCIAL SECURITY NO.				
14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO				DENTAL CARRIER		GROUP NO.		PHONE NO. AND ADDRESS OF CARRIER			
15. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. _____ SIGNED (PATIENT OR PARENT OF MINOR) DATE						I HEREBY AUTHORIZE PAYMENT TO THE BELOW NAMED DENTIST OF THE DENTAL PLAN BENEFITS OTHERWISE PAYABLE TO ME. _____ SIGNED (EMPLOYEE) DATE					

## PART 2 - DENTIST: READ INSTRUCTIONS CAREFULLY BEFORE YOU COMPLETE

16. DENTIST NAME				24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		YES	NO	IF YES, ENTER BRIEF DESCRIPTION AND DATES			
17. MAILING ADDRESS				25. IS TREATMENT RESULT OF AUTO ACCIDENT?							
CITY, STATE, ZIP				26. OTHER ACCIDENT?							
18. DENTIST SOC. SEC. OR T.I.N. NO.				19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		27. ARE SERVICES RELATED TO TMJ?			
21. FIRST VISIT DATE CURRENT SERIES				22. PLACE OF TREATMENT OFFICE HOSP ECF OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED? YES NO		28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		(IF NO, REASON FOR REPLACEMENT)	
29. DATE OF PRIOR REPLACEMENT				29. DATE OF PRIOR REPLACEMENT		30. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED ENTER:		DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	

<p>INDICATE MISSING TEETH WITH AN X</p>	31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32 - USE CHARTING SYSTEM SHOWN						FOR ADMINISTRATION USE ONLY			
	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO DAY YEAR	ADA PROCEDURE NUMBER	FEE	TYPE SERVICE I II III			
32. REMARKS FOR UNUSUAL SERVICES										

**PART 4**  
 I HEREBY CERTIFY THAT SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE PATIENT ON THE DATES INDICATED AND THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO THE MAJORITY OF MY PATIENTS.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
 (DENTIST)

<b>TOTAL FEE \$</b>	
<b>PART 3</b> THE PLAN BENEFITS INDICATED WILL BE PAYABLE IF THE SERVICES LISTED ARE PERFORMED WHILE THE PATIENT IS COVERED UNDER THIS PLAN, SUBJECT TO THE COORDINATION OF BENEFITS WITH OTHER PLANS.	

MUST BE FURNISHED UNDER AUTHORITY OF LAW WHEN BENEFITS ASSIGNED.

# **INSTRUCTIONS FOR FILING DENTAL CLAIMS**

## **INSTRUCTIONS TO EMPLOYEE:**

Complete Part 1 in full (please type or print). Incomplete information may delay servicing of your claim.

Give this form to your dentist after you have completed Part 1. If services exceed \$300, have your dentist submit a Pre-Determination Estimate to the Claims Department. The Claims Department will advise your dentist and yourself what the plan will pay.

## **INSTRUCTIONS TO DENTAL OFFICE:**

Complete the Dentist's portion of the claim form.

Have the employee sign the payment authorization block if payment is to be made directly to your office and forward original to the address shown on reverse.

If you are requesting a Pre-Determination of plan benefits, retain a copy of the Dental Claim Notice you have forwarded. Your office, and the employee will receive an explanation of benefits from the claims department. After the services have been performed, forward a copy of the Dental Claim Notice to the address shown on the reverse indicating the dates of service and any changes in the services originally reported.