HealthSmart

Dental Benefits Claim Form

Please mail completed form to:

HealthSmart Benefit Solutions ▪ P.O. Box 3262 ▪ Charleston, WV 25332 ▪ Toll Free 800-375-2910

Select one of the following:

○ Dentist's Pretreatment Estimate ○ Dentist's Statement of Actual Services

Patient's Section

Patient's Name	Relationship to Employee	Sex	Patient's Date of Birth (MM/DD/YY)	If Full-Time Student School / City
	○ Self ○ Spouse ○ Child ○ Other	○ M ○ F		

Employee's Name (First, Initial, Last)	Employee's Social Security Number	Employee's Telephone Number

Employee's Address	Employer's Name

City	State	ZIP

Group Number	Are other family members employed?	Name	Social Security Number	Name of Employer
	○ Yes ○ No			

Is patient covered by another dental plan?	Dental Plan Name	Group Number	Name and Address of Carrier
○ Yes ○ No			

Other Insurance

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

I hereby authorize payment of the group insurance benefits otherwise payable to me directly to the below-named dentist.

Signature-Patient or Parent (if Minor)	Date	Signature-Insured Person	Date

Dentist's Section

Dentist's Name					No	Yes	If yes, enter brief description and dates.
				Is treatment a result of occupational illness or injury?			
Address				Is treatment a result of auto accident?	No	Yes	
City	State	ZIP			No	Yes	
				Other Accident?			
Dentist SS No/TIN	Dentist Lic. No.	NPI	Dentist Ph. No.	Are any services covered by another plan?	No	Yes	

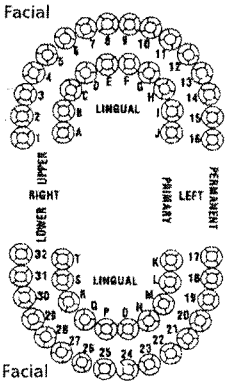
First Visit Date of Current Series	Place of Treatment			No	Yes	(If no, reason for replacement)	Date of Prior Placement
	○ Office ○ ECF ○ Hospital ○ Other		If prothesis, is this an initial placement?				

Radiographs/models enclosed?	How many?		No	Yes	If Services Already Commenced Enter	Date Appliances Placed	Months Treatment Remaining
○ Yes ○ No		Is treatment for orthodontics?					

Examination And Treatment Plan

Identify missing teeth with X.

Facial



Facial

Examination and Treatment Plan ▪ List in order from tooth 1 through 32, A through T, using chart at left.

Tooth # or letter	Surface	Description of Service (including X-rays, prophylaxis, material used, etc.)	Date of Service (MM/DD/YY)	Procedure Number	Fee	For Administrative Use Only

Remarks for unusual services.

I hereby certify that the procedures as indicated by date have been completed.

Signature (Dentist)	Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	