ATTENDING DENTIST'S STATEMENT

DENTAL PLUS CLAIM FORM

UNITED SECURITY INSURANCE COMPANY®
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Phone: 800-875-4422 • 708-475-6100
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PATIENT INFORMATION

1. PATIENT NAME FIRST MIDDLE LAST	2. RELATIONSHIP TO NSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	3. SEX M ☐ F ☐	4. PATIENT BIRTHDATE MO / DAY / YEAR	5. IF FULL-TIME STUDENT SCHOOL CITY
6. INSURED NAME FIRST MIDDLE LAST		7. INSURED SOCIAL SECURITY #		8. DENTAL PLUS POLICY #
9. INSURED MAILING ADDRESS		10. EMPLOYER (COMPANY) NAME AND ADDRESS		
11. INSURED OTHER DENTAL COVERAGE	12. POLICY #	13. ARE OTHER FAMILY MEMBERS EMPLOYED?		14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO	DENTAL PLAN NAME	GROUP #		NAME AND ADDRESS OF EMPLOYER

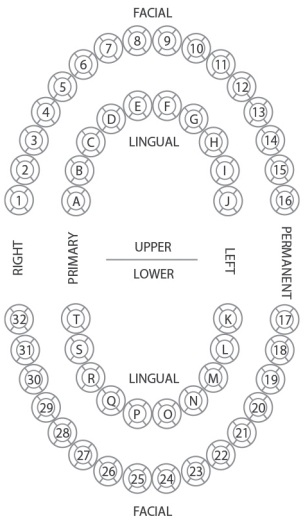
HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT

SIGNED (PARENT OF PATIENT IF MINOR) DATE

DENTIST INFORMATION

16. DENTIST NAME			24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
17. MAILING ADDRESS			25. IS TREATMENT RESULT OR AUTO ACCIDENT?			
			26. OR OTHER ACCIDENT?			
CITY	STATE	ZIP	27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
18. DENTIST SOC. SEC. or T.IN.	19. LICENSE #	20. DENTIST PHONE #	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PRIOR PLACEMENT
21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT OFFICE ☐ HOPS. ☐ ECF ☐ OTHER ☐	23. RADIOGRAPHS or MODELS ENCLOSED ☐YES ☐NO HOW MANY	30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
		1						
		2						
		3						
		4						
		5						
		6						
		7						
		8						
		9						
		10						
		11						
		12						
		13						
		14						
		15						

SEND RECEIPTS FOR PAYMENTS MADE TO DENTAL PROVIDER

TOTAL FEE ALLOWED	
MAX ALLOWED	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	