

INSURANCE CLAIM FORM FOR DENTAL CARE

A. CLAIMANT INFORMATION (To be completed by Insured)

Patient Name:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient Address:	Patient Insured Status: <input type="checkbox"/> Self <input type="checkbox"/> Dependant	
Enrollee Name:	Member ID:	Dependant Number:
Group Policy Number:	Group Name:	

<p align="center">CLAIMANT'S AUTHORISATION</p> <p>I authorise Cayman First to obtain medical records from any medical service provider, insurer, employer or other source deemed necessary to settle this claim.</p> <p>Signature _____ Date _____</p>	<p align="center">PAYMENT ASSIGNMENT</p> <p>I authorise Cayman First to pay the proceeds of this claim to the undersigned Dental Care Provider.</p> <p>Signature _____ Date _____</p>
---	--

B. DENTAL CARE SERVICES/ TREATMENT PROVIDED (To be completed by Dentist/ Dental Surgeon)

Dental Provider Name:	Telephone No.:
Dental Provider Address:	
Was treatment a result of an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, describe:	
If prosthesis, is this the initial placement? <input type="checkbox"/> No <input type="checkbox"/> Yes If No, explain reason for placement:	
Date of first visit for current series:	Is treatment for orthodontics? <input type="checkbox"/> No <input type="checkbox"/> Yes
For current series, months of treatment remaining	

USE "X" TO INDICATE MISSING TEETH	USE TOOTH CHART AT LEFT TO INDICATE TOOTH TREATED						
	DATE OF SERVICE	TOOTH LETTER	TOOTH SURFACE	DENTAL SERVICE	DENTAL CODE	FEE C/\$	INS. CO. USE ONLY

I hereby certify that this is a true statement of treatment and services rendered.	TOTAL FEES:	
	PAID BY PATIENT:	
	BALANCE DUE:	
Signature of Dental Care Provider _____	Date _____	