(PLEASE FILL OUT QUESTIONS 1 THROUGH 15 BEFORE GIVING TO YOUR DENTIST)

Acclaim

DENTIST'S INSTRUCTIONS
1. Complete the form below
2. Have employee/Patient sign at bottom
3. Send completed form to .....

ACCLAIM
808 Varsity Drive
Tupelo, Mississippi 38801
1-800-317-2324

ATTENDING DENTIST'S STATEMENT

1. Patient Name	2. Relationship to employee Self Spouse Child Other	3. Sex	4. Patient Birthdate Mo. Day Year	5. Insurance ID#

6. Employee Name (First) (Middle) (Last)	7. Employee SS#	8. Name of group Dental program / Group #

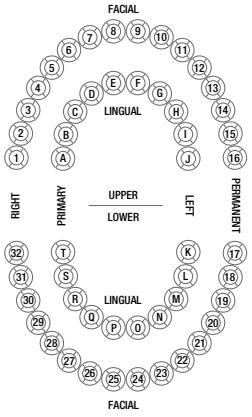
9. Employee Mailing Address	10. Employer (Company) Name and Address
City, State, Zip	City, State, Zip

11. Is patient covered by another dental plan? ❑ Yes ❑ No Dental Plan N Group No. Name and Address of carrier

12. Dentist Name	19. Is treatment result of occupational Illness or injury? NO ❑ YES ❑	If YES, enter frief description and dates
13. Mailing Address	20. Is treatment result of auto accident? ❑ ❑	
City, State, Zip	21. Other accident? ❑ ❑	
14. Dentist Tax No. 15. NPI No. 16. Dentist Phone No.	22. Are any services covered by another plan? ❑ ❑	
	23. If prosthesis, is this initial placement? ❑ ❑	If NO, Reason for replacement 28. Date of Last Placement
17. First Visit Date Current Series / 18. Place of Treatment Office Hosp Other	24. Is treatment for Othodonics? ❑ ❑	If services already commenced Enter / Date Appliances Placed / Mos. Treatment Remaining

CHECK ONE!
DENTIST'S
❑ PRE-TREATMENT ESTIMATE
❑ STATEMENT OF ACTUAL SERVICES

INDICATE MISSING TEETh WITH AN "X"



TOOTH OR LETTER	SURFACES	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DATE SERVICES PERFORMED MO	DAY	YEAR	ADA PROCEDURE NUMBER	FEE

TOTAL FEE ACTUALLY CHARGED	
MAX ALLOWED	
DEDUTIBLE	
BALANCE	
PATIENT CO-IN %	
TOTAL BENEFITS	

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE ❑ HAVE BEEN ❑ PERFORMED

SIGNED (DENTIST) DATE

COMPLETE AFTER SERVICES HAVE BEEN PERFORMED

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. I WISH TO ASSIGN BENEFITS TO THE ABOVE NAMED DENTIST. ❑ NO ❑ YES

I HAVE REVIEWED THE ABOVE TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

EMPLOYEE SIGNATURE DATE SIGNED (PATIENT, OR PARENT IF MINOR) DATE