COOPERATIVE BENEFIT ADMINISTRATORS, INC.

A SUBSIDIARY OF THE NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION

"Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and or civil penalties may result from such acts."

Dental Benefit Request Form

Patient Section

1. Patient name	2. Relationship to employee	3. Sex	4. Patient birthdate	5. Full-time student?
	☐ Self ☐ Child ☐ Divorced ☐ Spouse ☐ Other ☐ Widowed	☐ Male ☐ Female		☐ Yes ☐ No If Yes, where? School _____ City _____

6. Employee name	7. Member ID

8. Employee address and telephone number	9. Employer name and REA number

10. Are other family members employed?	11. Name and address of employer in item 10
☐ Yes ☐ No	

12. Is patient covered by another dental plan? ☐ Yes ☐ No If Yes, provide dental plan name:

Group no | Name and address of carrier | Telephone no:

13a. I certify that the above statements are true and correct. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.	13b. I hereby authorize payment directly to the attending dentist.
Patient's or authorized person's signature _____ Date _____	Signed (employee or authorized person) _____ Date _____

Dentist Section

14. Dentist name (first, middle, last)	15. Mailing address (address, city, state, ZIP code)	16. Dentist SSN or T.I.N.	17. Dentist license no.	18. Dentist phone no.

19. First visit date current series	20. Place of treatment	21. Radiographs or models enclosed?
	☐ Office ☐ ECF ☐ Hospital ☐ Other	☐ Yes ☐ No How many?

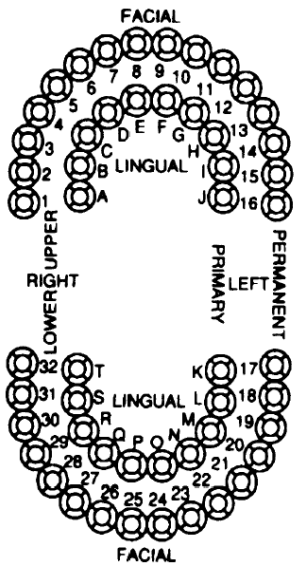
		No	Yes	If Yes, enter brief description and dates
22.	Is treatment result of occupational illness or injury?			
23.	Is treatment result of an auto accident?			
24.	Other accident?			
25.	Are any services covered by another plan?			
26.	If prosthesis, is this initial placement?			If no, reason for replacement / 27. Date of prior placement
28.	Is treatment for orthodontics?			Date appliances placed: _____ Mos. treatment remaining: _____

29. Dentist - Check One

☐ Pre-treatment estimate

☐ Statement of actual services

Identify missing teeth with (X)



30. Examination and treatment plan - List in order tooth no. 1 through no. 32
Use charting system shown

Tooth no. or letter	Surface	Description of services (including x-rays, prophylaxis, materials used, etc.)	Date services performed Mo.	Day	Yr.	Procedure number	Fee	

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

Signature _____ Date _____

TOTAL FEE CHARGED	
PATIENT PAYMENT	
BALANCE DUE	

How to Request Benefits

Employee

Complete items 1-13a on the reverse side of this form. If you wish to have benefits paid directly to your dentist, also sign 13b, the payment authorization.

Ask the dentist to complete items 14-30 or submit an itemized bill. An itemized bill lists the patient's name, relationship, date of service, the type of service rendered and the nature of the condition being treated, the dentist's or supplier's taxpayer identifying number, and if benefits are assigned.

Send the completed **Dental Benefit Request Form** directly to the address on the back of your medical ID card.

If you anticipate extensive dental work, you may submit a request for a pre-treatment estimate of benefits.

Dentist

Complete items 14-30 on the **Dental Benefit Request Form**. Check box 29 of form to indicate whether this form represents a request for a pre-treatment estimate or is a statement of services actually rendered.

If for a pre-treatment estimate, **leave the date blank** for those services that have not been completed. Our estimate and your x-rays will be returned to you promptly. Estimates are subject to deductibles and plan maximums and may be reduced by payments made before these services are rendered. The estimate is based on the assumption the patient will receive the services while covered and the treatment plan does not change. Actual payment may differ from the estimate.

Note: In order to expedite payment it is suggested that pre-treatment x-rays be submitted along with this attending dentist's statement when the course of treatment includes gold restorations, crowns, or bridgework. X-rays may also be requested for other services. X-rays will not be returned.