CLAIM FORM

P.O. Box 900
Elyria, OH 44036
800-223-9941
www.CommerceBenefitsGroup.com

☐ Pre-Treatment Estimate
☐ Charge for Service Performed

Commerce Benefits Group

DENTAL

EMPLOYEE COMPLETES THIS SECTION

LAST	FIRST	M.I.	Employer	SS#

SUBSCRIBER'S ADDRESS	STREET NO.	STREET NAME	CITY	STATE	ZIP CODE

PATIENT'S LAST NAME	FIRST	M.I.	SEX	BIRTH DATE MO. DAY YR.	RELATIONSHIP OF PATIENT TO SUBSCRIBER
					☐ SELF ☐ SPOUSE ☐ DEPENDENT CHILD — Dependent child age 19 and over: ☐ FULL TIME STUDENT ☐ HANDI—CAPPED

OTHER DENTAL INSURANCE? NO ☐ YES ☐

ACCIDENT? NO ☐ YES ☐

DATE OF ACCIDENT MO. DAY YR.

IF ACCIDENT DID IT OCCUR ON THE JOB? NO ☐ YES ☐

IF ACCIDENT WAS ANOTHER PERSON INVOLVED? NO ☐ YES ☐

OTHER INSURANCE COMPANY NAME

POLICY HOLDER OF OTHER INSURANCE

EMPLOYER OR OTHER POLICYHOLDER

AUTHORIZATION TO PAY DENTIST

Claimant's Signature Date

DENTIST COMPLETES THIS SECTION

ARE X-RAYS ENCLOSED? YES ☐ NO ☐

If YES INDICATE NUMBER_____

LINE NO.	TOOTH NO.	SUR-FACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO. DAY YR.	FEE FOR EACH SERVICE PERFORMED	PROCEDURE CODE NUMBER
01						7
02						7
03						7
04						7
05						7
06						7
07						7
08						7
09						7
10						7

LABIAL
LINGUAL
INDICATE MISSING TEETH WITH AN X
RIGHT LEFT UPPER LOWER PRIMARY PERMANENT
LINGUAL
LABIAL

PLACE OF SERVICE
1. ☐ IN-PATIENT C. ☐ OFFICE
2. ☐ OUT-PATIENT 4. ☐ HOME

WERE SERVICES INDICATED RENDERED FOR ORTHODONTIC PURPOSES? ☐ YES ☐ NO

PAGE TOTAL FEE ▶

IF PROSTHESIS IS THIS INITIAL PLACEMENT? ☐ Yes ☐ No

IF NO, DATE OF PRIOR PLACEMENT AND REASON TO REPLACE

GRAND TOTAL FEE ▶

ADDITIONAL REMARKS FOR UNUSUAL SERVICES

PROVIDER NAME, ADDRESS, AND PHONE NUMBER

Fed. ID #__________ Lic. #__________

I CERTIFY THAT THE ABOVE SERVICES ARE SUBMITTED FOR PREDETERMINATION OF BENEFITS, OR HAVE BEEN PERSONALLY PERFORMED BY ME, OR ARE APPROVED DENTAL HYGIENIST SERVICES SUPERVISED BY ME.

SIGNATURE DATE