CORESOURCE
A Trustmark Company

DENTAL CLAIM FORM

STANDARD FORM AND INSTRUCTIONS ARE ON BACK

Check one:
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

PATIENT SECTION

1. Patient name first m.i. last
2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other
3. Sex m f
4. Patient birthdate MM DD YYYY
5. If full time student school city
6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec. number
8. Employee/subscriber birthdate MM DD YYYY
9. Employer (company) name and address
10. Group number
11. Is patient covered by another plan of benefits? Dental ______ Medical ______
12-a. Name and address of carrier(s)
12-b Group no.(s)
13. Name and address of employer
14-a Employee/subscriber name (if different than patient's)
14-b Employee/subscriber soc. sec. number
14-c Employee/subscriber birthdate MM DD YYYY
15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other

16. I 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 (Patient, or parent if minor) ______ Date ______

DENTIST SECTION

18. Dentist name
19. Mailing address
City, State, Zip
20. Dentist Soc. Sec. or T.I.N.
21. Dentist license no.
22. Dentist phone no.
23. First visit date current series
24. Place of treatment: Office, Hosp., ECF, Other
25. Radiographs or models enclosed? No Yes How Many?

	No	Yes	
26. Is treatment result of occupational illness or injury?			If yes, enter brief description and dates.
27. Is treatment result of auto accident?			
28. Other accident			
29. Are any services covered by another plan?			
30. If prosthesis, is the initial placement?			(If no, reason for replacement) — 31. Date of prior placement
32. Is treatment for orthodontics			If services already commenced enter: Date appliances placed — Mos. treatment remaining

33. What amount has patient paid $ ______
34. Circled fees todays charges $ ______
35. ☐ PRE TREATMENT ESTIMATE $ ______

DIAGNOSTIC

SERVICE DATE — FEE

- INITIAL 0110 EXAM ______ PERIODIC 0120 EXAM ______
- 0130 EMERGENCY EXAM
- 0210 FULL SERIES/INC. B.W.
- 0220 SINGLE FIRST X-RAY
- 0230 ADDITIONAL #______
- 0270 BITEWING X-RAY
- 027__ ADDITIONAL #______
- 0330 PANOREX/INC. B.W.
- 0470 DIAGNOSTIC MODELS

PREVENTIVE

- 1110 ADULT ______ 1120 CHILD
- 12__ FLUORIDE

AMALGAM RESTORATIONS

TOOTH — SURFACES

- 21__
- 21__
- 21__
- 21__
- 21__
- 21__
- 219 __PIN RETENTION

COMPOSITE RESTORATIONS

SURFACES

- 23__
- 23__
- 23__
- 23__
- 23__
- 23__
- 2951 _PIN RETENTION

PROSTHETICS

SERVICE DATE — COMPLETE — FEE

- 5110 UPPER DENTURE
- 5120 LOWER DENTURE

IMMEDIATE

- 5130 UPPER DENTURE
- 5140 LOWER DENTURE

PARTIALS

- 52__UPPER
- 52__LOWER
- 5630 ADDL. CLASP
- 56__DENTURE REPAIR #
- 57__RELINE ______U ______L

*PERIODONTICS

- 4210 GINVIVECTOMY AREA
- 4220 CURETTAGE AREA
- 4260 OSSEOUS SURGERY AREA
- 4341 SCALING/ROOT PLANE AREA
- 4910 PERIODONTAL PROPHY

GENERAL ANESTHESIA

- TIME ______
- 9110 PALLIATIVE TREATMENT
- TOOTH # ______

OTHER

ENDODONTICS

SERVICE DATE — TOOTH — FEE

- 3110 PULP CAP DIRECT
- 3220 PULPOTOMY

ROOT CANAL

- 3310 ANTERIOR
- 3320 BICUSPID
- 3330 MOLAR

EXTRACTIONS

- 7110 SIMPLE
- 7120 EACH ADDL.
- #______

IMPACTIONS

- 7220 SOFT TISSUE
- 7230 PARTIAL BONY
- 7240 FULL BONY
- 7241 COMPLICATED*

*CROWNS (INDIVIDUAL)

- 27__
- 27__
- 27__
- 27__
- 27__
- 2920 Recement Crown
- 2950 PIN BLD. UP
- 2952 ___POST & CORE

*FIXED BRIDGE

- 6__
- 6__
- 6__
- 6__
- 6__
- 6930 Recement Bridge
- 6970 _POST & CORE

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Dentist) ______ Date ______

*SUBJECT TO SUBMISSION OF TREATMENT PLAN & X-RAYS

INSTRUCTIONS

HOW TO FILE A CLAIM

Complete questions 1 through 15 and sign on line 16.

Ask your dentist to complete the claim form after examination. The dentist should show the full treatment plan.

PREDETERMINATION

If a course of treatment can reasonably be expected to be less than $300, the form can be submitted when treatment is completed.

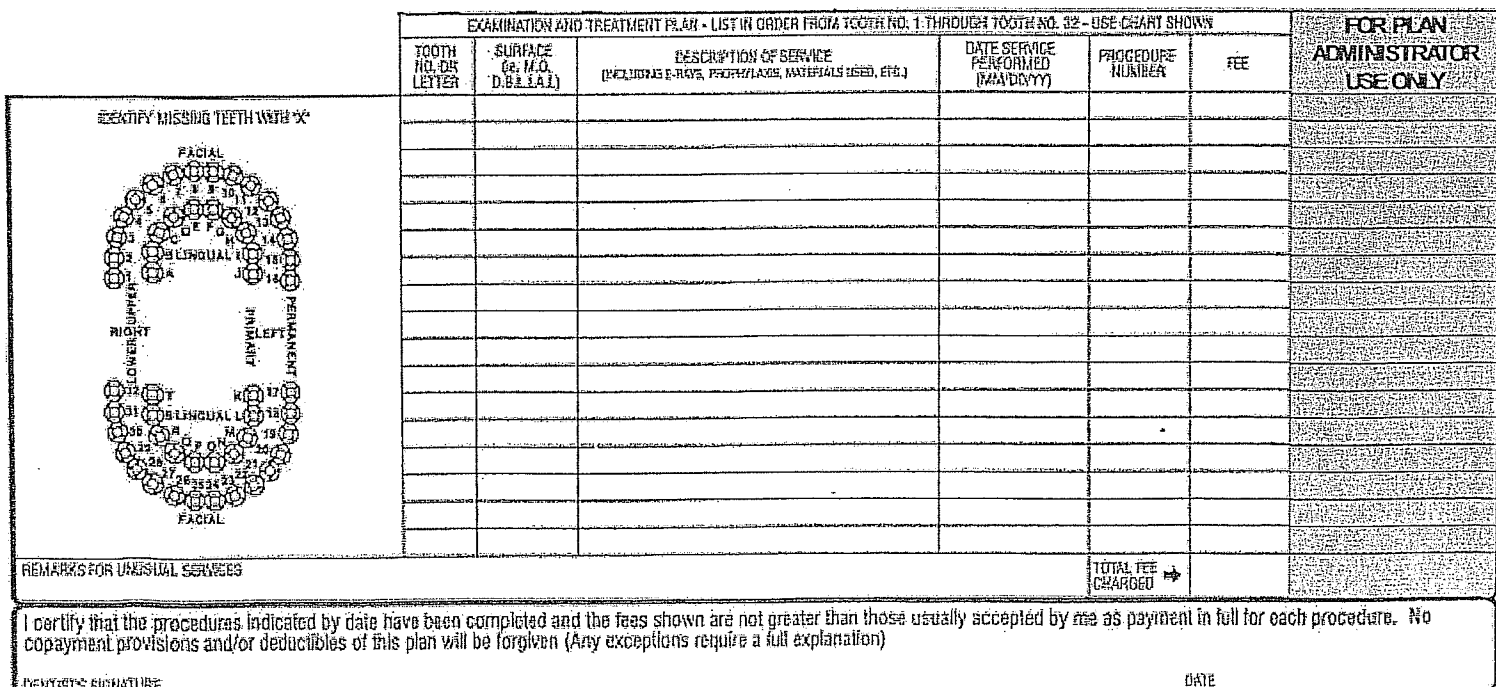
If a course of treatment can reasonably be expected to be $300 or more, follow these steps.

a. Complete questions 1 through 15.
b. Give the claim form to your dentist.
c. Have your dentist complete his section of the claim form, showing a description of the procedures to be performed and the proposed fees. Your dentist should submit the completed form, with x-rays to CoreSource, Inc at the address below.
d. CoreSource, Inc will review the description of the procedures to be performed and the charges, and will notify you and your dentist of the benefit payable.
e. After the dentist completes the work, he should indicate on the claim form the specific services performed, dates of service, and the charges. Your dentist should send the complete claim form to CoreSource, Inc at the address below.

   X-rays must be submitted with the claim form whenever the charge for the treatment plan is more than $300.

Claim forms and questions should be directed to:

CoreSource, Inc
P.O. Box 2920
Clinton, IA 52733-2920
1-800-624-7130



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

TOOTH NO. OR LETTER	SURFACE (e. M.O. D.B.L.I.A.I.)	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED (MM/DD/YY)	PROCEDURE NUMBER	FEE	FOR PLAN ADMINISTRATOR USE ONLY

REMARKS FOR UNUSUAL SERVICES

TOTAL FEE CHARGED ➜

I certify that the procedures indicated by date have been completed and the fees shown are not greater than those usually accepted by me as payment in full for each procedure. No copayment provisions and/or deductibles of this plan will be forgiven (Any exceptions require a full explanation)

DENTIST'S SIGNATURE ______________________ DATE ________