SOUTH POINT BENEFITS

WHERE TO SEND A CLAIM:
SOUTH POINT BENEFITS
9777 Las Vegas Blvd. South
Las Vegas, NV 89183

DENTAL CARE CLAIM FORM

PATIENT NAME (FIRST)	LAST	RELATIONSHIP TO EMPLOYEE: SELF / SPOUSE / CHILD / OTHER	SEX: M / F	PATIENT BIRTHDATE: MO. / DAY / YEAR	IF FULL TIME STUDENT, COMPLETE IN REMARKS BELOW*

EMPLOYEE NAME (FIRST)	MIDDLE	LAST	EMPLOYEE SOCIAL SECURITY NO.	NAME OF EMPLOYER

EMPLOYEE HOME ADDRESS	MARITAL STATUS	*REMARKS — NAME/ADDRESS OF SCHOOL
CITY, STATE, ZIP	☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Legally Separated	

ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ Yes ☐ No	EMPLOYEE NAME	NAME AND ADDRESS OF SPOUSE'S EMPLOYER		
IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ Yes ☐ No	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER

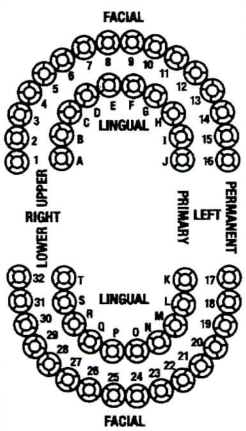
A. I authorize my attending dentist to release my information relating to the claim	B. I hereby certify to the above statements	C. I hereby authorize payment direct to the below named dentist
SIGNED (PATIENT OR PARENT IF MINOR) DATE	EMPLOYEE SIGNATURE DATE	EMPLOYEE SIGNATURE DATE

		NO	YES	
DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?			IF YES, ENTER BRIEF DESCRIPTION AND DATE
CITY STATE ZIP	ARE ANY SERVICES COVERED BY ANOTHER PLAN?			IF YES, ENTER NAME OF PLAN
DENTIST SOC. SEC. OR TIN. / DENTIST LICENSE NO. / DENTIST PHONE NO.	IF PROSTHESIS, CROWN, OR INLAY, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT (DATE OF PRIOR PLACEMENT)
FIRST VISIT DATE CURRENT SERIES / PLACE OF TREATMENT: OFFICE / HOSP / ECP / OTHER / RADIOGRAPHS OR MODELS ENCLOSED? NO / YES / HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF YES, DATE OF EXTRACTIONS

DENTIST — CHECK ONE

☐ PRETREATMENT ESTIMATE
☐ STATEMENT OF ACTUAL SERVICES

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN

TOOTH NO. OR LTR	SURFACE	DESCRIPTION OF SERVICES (Including X Rays, Prophylaxis, Materials Used, etc.)	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE	ADMINISTRATIVE USE ONLY: BASIC	MAJOR
						TOTAL FEE CHARGED			

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

SIGNED (DENTIST) DATE

REMARKS ____________________

PAYMENT NOTATION	IF APPLICABLE	DEDUCTIBLE		
Certificate Number		% Payable		
Incurred Dates		Amount Payable		
Payee	*These insurance benefits will, subject to policy provisions, be payable if the described procedures are performed during a period of the patient's eligibility. (The patient's personal eligibility has not been verified at the time of predetermination.)*			
		INSURANCE PAYS		
		PATIENT PAYS		