

STANDARD DENTAL CLAIM FORM



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												Please	orint						-			Insurance Association
PA	RT 1	DE	NTI	ST									UN	IQUE N	10.	SI	PEC.		PATIEN	NT'S OF	FICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE
ΡL	AST N	AME									GIV	EN NAM										NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.
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N (T												TAL COD										
FOR									AL INFORM	ATIO	N, DI	AGNOSIS	s, I UI	I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY								
PRC	CEDU	RES,	OR	SPE	CIA	L CO	NSIDE	RATION														SIBLE TO MY DENTIST FOR THE ENTIRE IS ACCURATE AND HAS BEEN
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